DEPT.- 65

JOB- 21

REEL- 53

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C. P. Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec—12-23-21—E.B.R.S.—400 Blks.

41806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91806

CERTIFICATE OF DEATH.

1885 D 91806

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1425 W Biddle St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira Spriggs

(a) Residence No. 1425 W Biddle St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Spriggs

6-DATE OF BIRTH (month, day and year) Apr. 24-1854

7-AGE. 70 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Alexander

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hannah Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-

(Informant) William H. Spriggs

(Address) 425 W. Biddle St

15-

Filed NOV 9 - 1924 19?

ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 6/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 19 24 to Nov 6 19 24

that I last saw h[illegible] alive on Nov 5 19 24

and that death occurred, on the date stated above, at 6 30 a.m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Hip

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Chevalier M. D

Nov 7 19 24 (Address) 1504 McCulloh

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Garrison Forest, Md. DATE OF BURIAL. Nov. 7th 19 24

20-UNDERTAKER, Jno. M. Johnson ADDRESS 1309 Druid Hill Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

91807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91807

REGISTERED NO. D 91807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Ridgely ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bantha Miller

(a) RESIDENCE NO. 1003 Ridgely ST., 21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of [illegible] Frederick Miller

6 DATE OF BIRTH (month, day, and year) Mar 6 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Hantwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mrs Kuder. N.A.D. 1927

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo. Miller

(Address) 1003 Ridgely St.

15 NOV 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1924, to Nov. 7, 1924,

that I last saw h[illegible] alive on Nov. 6, 1924

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1927 (Address) 1729 Bank Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London P.K.

DATE OF BURIAL: 11/10/24

20 UNDERTAKER: Geo Lembach & Son

ADDRESS: 624 Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.F. R.S.—400 Blks.

91808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91808

1-PLACE OF DEATH D 91808 Registered No.

City of BALTIMORE. (No. 619 S. 17th St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Griffin

(a) Residence No. 619 S. 17th St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Griffin

6-DATE OF BIRTH (month, day and year) Nov. 1—1874

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER. James Matthew

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Maria Sinclair

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) John J. Griffin

(Address) 619 S. 17th St.

15- NOV 9 - 1924 ROBERT A. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1924 to Nov 7th 1924

that I last saw her alive on Nov 6th 1924

and that death occurred, on the date stated above, at 3.40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Adam Tod M. D

, 19 (Address) 4704 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL. Nov. 10 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-22—M&T—100 Blks.

91809 / 1924 / 44

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91809

CERTIFICATE OF DEATH.

D 91809

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 S. Eutaw ST. 21 WARD) Eutaw 90

REGISTERED NO. 880

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Reese

(a) RESIDENCE NO 1014 S. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col'd

5 Single, Married, Widowed, or Divorced (write the word) ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Robt Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Nancy Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Mrs L J Harrison (Address) Veteran and Chicago

15 Filed NOV 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. H. Kelly, Coroner, M. D.

Nov. 6, 1924 (Address) 1239 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion

DATE OF BURIAL Nov 10 1924

UNDERTAKER Fannie E. Wright

ADDRESS Catonsville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Falls Road Terraces ST., 13 WARD)

2-FULL NAME Emma Jane Hoofnagle

(a) RESIDENCE NO. 609 Falls Road Terraces ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

D 91810

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 70	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Howard Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant C. Foster Talbott

(Address) 609 Falls Road Terraces

15 Filed NOV 9 - 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7. 1924 19

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1924, to Nov 7, 1924.

that I last saw ~~her~~ alive on Nov 7, 1924

and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hemiplegia

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical findings

(Signed) C. Foster Talbott, M. D.

11/8. 1924 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11-10-24 19

20 UNDERTAKER H. E. Hughes. ADDRESS 424-N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

91811

HEALTH DEPARTMENT—CITY OF BALTIMORE

"D 91811

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

"D 91811

Registered No.....

City of BALTIMORE: (No. 414 N. Bruce St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary E. Sands .....

(a) Residence No. 414 N. Bruce St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Sands

6-DATE OF BIRTH (month, day and year) Nov. 25-1871

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House work

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER John O'Day

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Cochran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mr John E. Sands

(Address) 414 N. Bruce St.

15- Filed ..... 192.

ROBERT A. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-6-24

17- I HEREBY CERTIFY, That I attended deceased from June 11th 23 to Nov 6th 24

that I last saw h alive on Nov 6th 24

and that death occurred, on the date stated above, at 9 00 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

2nd attack

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

11/7, 192 (Signed) B. Dorsey, M. D.

(Address) 400 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. Nov. 10 1924

20-UNDERTAKER John F. Cowan & Son, Ltd. ADDRESS 921 Holliday St

---

N. B.—WHILE PERFECT RECORDS, WITH ORIGINAL INFORMATION, IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

91812

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 91812

CERTIFICATE OF DEATH.

100-001

D 91812

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 19 W. Barry St. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Perraino

(a) Residence No. 19 W Barry St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 5, 1924

7-AGE. ....yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or....mtn.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Francis Perraino.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mannie Scardino

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mr Francis Perraino

(Address) 19 W Barry St

NOV 3 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 7 1924

15- I HEREBY CERTIFY, That I attended deceased from Nov 5, 1924 to Nov 7, 1924

that I last saw h[illegible] alive on Nov 7, 1924

and that death occurred, on ~~the date stated~~ above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 2 1 ds.

CONTRIBUTORY (Secondary) Age (4 mos.)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Exam. Chest etc.

(Signed) Harry Jenden M. D.

, 19 (Address) 1244 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Lucies Cem

DATE OF BURIAL. Nov 10, 1924

20-UNDERTAKER. John E Cowan & Son

ADDRESS 701 Hollins St

E. J. Cowan

---

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

91813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 91813

D 91813 DEATH

Registered No.

City of BALTIMORE: (No. 817 N. Stricker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Mulligan

(a) Residence No. 817 N. Stricker St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11/8/24

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 8 hrs. or 30 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md
(State or Country).

PARENTS

10-NAME OF FATHER, James B. Mulligan

11-BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or Country).

12-MAIDEN NAME OF MOTHER, Ruth Lewis Russell

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or Country).

14- (Informant) James Mulligan
(Address) 817 N. Stricker St.

15- NOV 9 - 1924 ROBERT P. KRAUTER, Registrar.
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/8/24

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw her alive on 11/8/24 19.....
and that death occurred, on the date stated above, at 2.35 P. M.
The CAUSE OF DEATH* was as follows:
congenital asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Parsons M. D
. 19 (Address) 1702 Westwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Zion	11/9/ 1924
20-UNDERTAKER, Joseph A Lisby	ADDRESS (57) Hunter Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stoer.—6-9-19—H. P. Co.—1000 Blks.

✓ 91814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91814

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

57

D 91814

REGISTERED NO.

CITY OF BALTIMORE: (No. 868 W Lombard ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Klein

(a) RESIDENCE. No. 868 W Lombard ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ~~34~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Klein

6 DATE OF BIRTH (month, day, and year): July 8 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Rosenstadt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Louis W Klein
(Address): 868 W Lombard.

NOV 9 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Nov 7, 1924, that I last saw her alive on Nov 6, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Diabetes — Millitis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Ca Stomach

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual.

(Signed) Edw Crumplen, M. D.

11/5/, 1924 (Address) 517 Leadenhall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cemetery	11/11/24 19
20 UNDERTAKER	**ADDRESS**
Harry A. Wetzke	1531 W Lombard St

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

91815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91815

CERTIFICATE OF DEATH.

66 D 91815

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1b.)

CITY OF BALTIMORE: (No. 1024 Hollins St. WARD)

2-FULL NAME Clarence Thompson

(a) RESIDENCE No 723 W Lexington ST., WARD 18

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	5	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Mary Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Charles H. Keefer
(Address) 104 Oakley Ave

15 Filed ... 1924 MYERS A. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism
Sudden
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)
Nov 8th, 1924 (Address) Curtis Bay.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional advice.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Nov. 10, 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Harlem

TION is very important. See instructions on back of certificate.

Cor.—t-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91816

CERTIFICATE OF DEATH.

D 91816

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 E Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L Dougher
Alderson W Va

(a) RESIDENCE NO. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Dougher

6 DATE OF BIRTH (month, day, and year) May 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Road Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Patrick Daugher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs J L Dougher
(Address) Alderson W Va

15 NOV 10 1924

Registrar

Local Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cancer of Urinary Bladder
(Was patient at Johns Hopkins) (Duration) yrs. mos.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S Sadler M. D.
(Coroner.)
Nov 9, 192 (Address) 5086 Monta

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
White Sulphur Spring W Va	Nov 9 24 192
20 UNDERTAKER Jack Lewis 1439 L	ADDRESS Balti 814 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91817

CERTIFICATE OF DEATH.

38 D 91817

1-PLACE OF DEATH

Registered No.

City of BALTIMORE; (No. 920 Roach al St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Todd

(a) Residence No. 920 Roach al St., 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Known

14-

(Informant) Chas Rice

(Address) 920 Peach alley

15-

NOV 1 0 1924

Registrar.

District Record Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11/7/24

17- I HEREBY CERTIFY, That I attended deceased from 11/6/24 to 11/7/24

that I last saw her alive on 11/7/24

and that death occurred, on the date stated above, at 12:00 N.

"The CAUSE OF DEATH" was as follows:

Ruptured aneurism of abdominal aorta

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

Cause Unknown (Duration) Abt 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno Porter, M. D.

11/8/24, 19 (Address) 918 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Ct

DATE OF BURIAL, 11/10-, 19 24

20-UNDERTAKER, Wm Lee Thomas & Son

ADDRESS 108 N Mount St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91818

CERTIFICATE OF DEATH.

1924 D 91818

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hospital (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Edward Noonan

(a) RESIDENCE No. 2028 Herbert St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret.

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Noonan
(Address) 2028 Herbert St

15 Burial Permit Clerk. NOV 10 1924 HOBART R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Street car accident (Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 16 ds.

(Signed) D. J. Hennessy, M. D.
(Coroner.)

Nov. 6, 1924 (Address) 2102 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 11-10 1924

20 UNDERTAKER M. Faher + Sons — ADDRESS 1927 W. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91819

CERTIFICATE OF DEATH.

D 91819

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Mt. Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Casey

(a) Residence No. Mt. Hope Retreat St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 8 1866

7-AGE, 58 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9-BIRTHPLACE (city or town) Philadelphia
(State or Country), Pa.

PARENTS.

10-NAME OF FATHER, James J. Casey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine S. Gordon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mt. Hope Retreat
(Address) Baltimore Md

15- Filed NOV 10 1924 ROBERT F. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Nov 9, 1924, that I last saw him alive on Nov 9, 1924, and that death occurred, on the date stated above, at 1.45 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Hilton P. Hill M. D.

, 19 (Address) Wyke Av. Roslyntown R1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem. Phila. Pa.	Nov. 11 19
20-UNDERTAKER, Margaret L. Flynn	ADDRESS 1122 Light St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91820

CERTIFICATE OF DEATH.

129 D 91820

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Emmet Ave ST. 17 WARD) Lauraville

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Joseph Long.

(a) RESIDENCE NO. 204 Emmet Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Long

6 DATE OF BIRTH (month, day, and year) July 1, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61.	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bartender

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Ireland

PARENTS

10 NAME OF FATHER Henry Long

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Tarvey

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Informant Mrs Annie M. Long

(Address) 204 Emmet Ave

15 Filed NOV 10 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to Nov. 8, 1924.

that I last saw him alive on Nov. 8, 1924

and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Decompensated Mitral Regurgitation

Chronic Interstitial nephritis

(duration) yrs. 4 mos 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos F. A. Stevens, M. D.

11/8 1924 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov. 12 1924
20 UNDERTAKER Margaret L. Glenn	ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9182 — 90 D 9182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bucks Ave nr Thorndon (STREET OR WARD)

2-FULL NAME Thomas Oslie Coard

(a) RESIDENCE NO. Bucks Ave nr Thorndon WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lelia N Coard

6 DATE OF BIRTH (month, day, and year) June 30, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Coard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nancy Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Florence M. Allender (Address) Bucks Ave.

15 Filed NOV 1 0 1924

12 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 19 24 to Nov 6, 19 24 that I last saw him alive on Nov. 6 19 24 and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows: Valvular disease of the heart & Chronic nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Robt F Haedrich M. D.

19 (Address) 1st E Pat & Register Resistertan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Nov. 11 1924

20 UNDERTAKER: Wm J Dickel Sons ADDRESS: North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91822

89 D 91822

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 W. Woodland Ave. St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm G. Hearn

(a) RESIDENCE NO. 210 W. Woodland St. Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Lee Hearn

6 DATE OF BIRTH (month, day, and year) May 24 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer Lafayette Lumber Mill

9 BIRTHPLACE (city or town) (State or country) Sussex Co Del

PARENTS

10 NAME OF FATHER Geo Henry Hearn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Amanda Melvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Mrs Frances L Hearn

(Address) 210 W. Woodland Ave.

15 Filed NOV 10 1924 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 1924, to Nov. 7 1924, that I last saw h in alive on Nov. 7th 1924, and that death occurred, on the date stated above, at 1245 p. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis and angina pectoris

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dialalation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical symptoms

(Signed) Benj. Kader, M. D.

. 19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov. 10, 24
20 UNDERTAKER Wm H Tickner Sons	ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 91823

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital ST., 23 WARD)

2-FULL NAME Mrs Bessie Flashman

(a) RESIDENCE NO. 1031 S. Charles St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel N Flashman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. wife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Balber

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Lipman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hosp Records
(Address)

15 Filed NOV 10 1924 ROBERT R. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/24

17

I HEREBY CERTIFY, That I attended deceased from 10/26, 1924, to 11/9, 1924, that I last saw her alive on 11/9, 1924 and that death occurred, on the date stated above, at 7:50 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Lab.

(Signed) Isidore L. Fine, M. D.

Nov. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run | DATE OF BURIAL 11/10 19 24

20 UNDERTAKER Jack Lewis | ADDRESS 1434 E Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91824

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1628 Hanover St., 23 Ward) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth G Eckmeyer

(a) Residence No. 1628 Hanover St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 15 1924

7-AGE. ....yrs. 3 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Herman B Eckmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Smyth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Newport Ky.

14- (Informant) Mrs Margaret Eckmeyer

(Address) 1628 Hanover

15- Filed ..... 19.. HOBART R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 9/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924 to Nov 8, 1924

that I last saw h alive on Nov 8, 1924

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinically

(Signed) W. L. L. Campbell M. D.

Nov 8, 1924 (Address) 1674 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross, A A Co Md — DATE OF BURIAL. Nov 10 1924

20-UNDERTAKER. John F Denny — ADDRESS 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91825

CERTIFICATE OF DEATH.

D 91825

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1205 E. Federal Street St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Fallon

(a) Residence No. 1205 E. Federal Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara A. Fallon

6-DATE OF BIRTH (month, day and year) Dec. 25, 1866

7-AGE			If LESS than 1 day
57 yrs.	10 mos.	13 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Guard at

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Pennitentary

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER Malinken Fallon

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Honora Fallon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Mrs. Clara A. Fallon

(Address) 1205 E. Federal Street

15- Filed ....., 192.... ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 8-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 4-24, 19.... to Nov. 8-24, 19....

that I last saw h alive on Nov. 8-24, 19....

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Infarct

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) + J. D. Haussman M. D.

(Address) 1936 Bolton

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	11/11. 19.24
20-UNDERTAKER	**ADDRESS**
George J. Ruth	1735 HARFORD AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91826

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Presstman ST., 15 WARD)

2-FULL NAME Paul Jerome Blake

(a) RESIDENCE No. 1625 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): X

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): June 25, 24.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Hilary Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Berta Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bertha Blake

(Address) 1625 Presstman St.

NOV 10 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1924, to Nov 8, 1924, that I last saw him alive on Nov 6th, 1924 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harvey F. Brown, M. D.

, 19 (Address) 501 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 10 1924

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1463 Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Snec

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91827.

9 D 91827.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 S Streeter St., 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Monika Snec

(a) RESIDENCE No. 430 S Streeter St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 27 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ernest Snec

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Ida Porusiewicz

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mrs Ernest Snec Father (Address) 430 S Streeter

15 Filed NOV 10 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1924, to 11/8, 1924, that I last saw her alive on 11/8, 1924, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) ..... yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James H Dorsey M. D.

11/8, 1924 (Address) 1729 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Nov 10 1924

20 UNDERTAKER John H Weber — ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91828

CERTIFICATE OF DEATH.

129 D 91828

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1213 Edmondson Ave. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza W. Goss,

(a) Residence No. 1213 Edmondson Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single, Married~~ Widow Widowed, ~~or Divorced~~. (Write the word.)

5a-If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of W.S.Goss.

6-DATE OF BIRTH (month, day and year) July 10.1840

7-AGE. 84 yrs. 3 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Stewart.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Sarah Vanwyck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Wm.A.Giles,

(Address) 1213 Edmondson Ave.

15- Filed NOV 10 1924 ROBERT R. KRAUTH, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) NOV 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19 24 to Nov. 7th 19 24

that I last saw her alive on Nov 7th 19 24

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Thomas Talbert, M. D.

NOV 8 1924 19 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL, Baltimore DATE OF BURIAL, NOV 10 1924 19

20-UNDERTAKER. Geo W Little ADDRESS 2740 EDMONDSON AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—4-10-21—M&T—1500 Blks.

D 91829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91829

CERTIFICATE OF DEATH

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 706 E. Fayette ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo. H. Simmons

(a) RESIDENCE NO. 903 S. Bentalou ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie M. Simmons

6 DATE OF BIRTH (month, day, and year): Sept 26-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Leo Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant (Address): Minnie M. Simmons 903 S. Bentalou St.

15 Filed NOV 10 1924 19 Registrar: J. KRAUTER, Deputy Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1924

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1924, to November 8, 1924.

That I last saw him alive on November 8, 1924,

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction, cured.

(duration) — yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? At his home

Did an operation precede death? Yes Date of Oct. 28, 1924

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis, Blood chemistry, etc.

(Signed) A. L. Yeppner, M. D.

11/8, 1924 (Address) 1102 No. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

12 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 11 1924

13 UNDERTAKER: A. J. Keppit

ADDRESS: 2236 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—AGE should be carefully supplied. AGE mation should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 91830 AT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1212 Mt Mount St., (Ave., Pl.) WARD) 16 + 57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Womer

(a) RESIDENCE NO. 1126 H. St. Spruce St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine

6 DATE OF BIRTH (month, day, and year) June - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Wm H Womer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret Hann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant James F Womer

(Address) 1126 H St Spruce St

15 NOV 10 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-7, 1924, to 11-8, 1924,

that I last saw him alive on 11-8, 1924,

and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

diabetic acidosis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) uraemia (duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? laboratory

(Signed) A. C. Mornnger, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spruce Point / Lewistown Pa

DATE OF BURIAL 11/10 1924

20 UNDERTAKER E LeRoy Shipley

ADDRESS 120 E North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91837

CERTIFICATE OF DEATH.

D 91837

REGISTERED No. C 15 121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2951 Clifton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss I. Marg. Wingate

(Residence in Baltimore: No. 2951 Clifton Ave St.; 9yr. yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, March 31st, 1897. (Month) (Day) (Year)

7-AGE, 27 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md -

PARENTS.

10-NAME OF FATHER, Albert L. Wingate

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Smith.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter G. Blizzard

(Address) 2951 Clifton Ave.

15- NOV 10 1924 ROBERT N. KRAUTER, Registrar

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9th, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 28th 1924, to Nov. 9th 1924, that I saw her alive on Nov. 9th 1924 and that death occurred, on the date stated above, at 7.45a m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis terminating in Uremia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Isaac C. Dickson M. D.

Nov. 9th, 1924 (Address) 3055 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Salisbury Md	Nov. 10, 1924
20-UNDERTAKER	ADDRESS
Josiah Dyer	1600 N. North Ave

Cor.—1-12-23—M&T—160 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91832

CERTIFICATE OF DEATH.

17

D 91832

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 312 Augusta av (WARD) 17th

2-FULL NAME Geo. H. Dietrich

(a) RESIDENCE NO. 312 Augusta ST. 17th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Dietrich

6 DATE OF BIRTH (month, day, and year) Jan 13/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None-
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John M. Dietrich

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Hoffrich

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant W. G. Dietrich
(Address) 312 Augusta ave

15 NOV 10 1924 Filed ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shot self through head

(Duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.
(Coroner)

Nov 7 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Nov. 10 1924

20 UNDERTAKER George L. Schwartz ADDRESS 1101 Ludlow.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91833

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 S. Linwood Ave St., [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Burke Jr.

(a) Residence No. 517 S. Linwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella L. Burke

6-DATE OF BIRTH (month, day and year) March 15-1864

7-AGE. 60 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Dept

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Wm. Burke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Don't know

14- (Informant) Wm. P. Burke Jr.

(Address) 517 S. Linwood Ave

NOV 10 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 7-1924.

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1924 to Nov 6 1924

that I last saw h... alive on ... 19...,

and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pharynx

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reifschneider M. D.

11/8 1924 (Address) 2934 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cems	Nov. 11 1924
20-UNDERTAKER, Zirkler & Zirkler	ADDRESS 1739 E. Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stock—6-9-19—H. P. Co.—1000 Bks.

D 91834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91834

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 121 McMechen ST. 14 WARD)

2-FULL NAME Lena Pendleton

(a) RESIDENCE. No. 121 McMechen ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Jan 4 1860

7 AGE — Years: 64 Months: 10 Days: 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Woman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER Adelbert Fernau

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Mrs. Ella Adams 121 McMechen

15 Filed NOV 10 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8th 1924.

17 I HEREBY CERTIFY, That I attended deceased from November 1918 to November 8th 1924.

that I last saw her alive on November 7th, 1924.

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis with Myocarditis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebritis Immediate.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar D. Perkins, M. D.

, 19 (Address) 1 W. Franklin St. Rochambeau

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 12 24

20 UNDERTAKER: George J. Smith — ADDRESS: 153 2 Hollins St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91835

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1535 Ellamont St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward P. Haye

(a) Residence No. 1535 Ellamont St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Mary E. Haye

6-DATE OF BIRTH (month, day and year) Aug. 13, 1841

7-AGE 83 yrs. 2 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER Robert Haye

11-BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12-MAIDEN NAME OF MOTHER Mary MacDowell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14-Informant Mary E. Vorsteg

(Address) 1535 Ellamont St

15-FILED NOV 10 1924 [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 8, 1924

17-I HEREBY CERTIFY, That I attended deceased from Oct-18 1924 to Nov-8- 1924

that I last saw him alive on Nov 7- 1924

and that death occurred, on the date stated above, at 3.40A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -

(Duration) ..... yrs. ..... mos. 22 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? None

(Signed) E. Gill Hall M. D

Nov-8. 1924 (Address) 1631 E North Ave -

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL Greenmount — DATE OF BURIAL Nov. 11, 1924

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 91836 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2521 Ashland Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer W. Pridgeon Jr.

(a) Residence No. 2521 Ashland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) October 29/24

7-AGE. ....yrs. ....mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Elmer W. Pridgeon Sr

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER, Marie C. Schwartz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md

14- (Informant). Elmer W. Pridgeon

(Address) 2501 Ashland ave

15- [illegible] 2?2?61 E. KRAUTER, Burial Permit Clerk.

NOV 10 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). November 9/24

17- I HEREBY CERTIFY, That I attended deceased from November 7, 1924 to November 8, 1924

that I last saw h~~im~~ alive on November 8, 1924

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Nov 9. 1924 (Address) 2005 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL, Nov 11, 1924

20-UNDERTAKER. Zirkler & Zirkler — ADDRESS 1734 Eager st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91837

CERTIFICATE OF DEATH.

90 D 91837

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stew Swiderski

(a) RESIDENCE NO. 11 Chem St Curtis Bay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria ?

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Frank Czaczka
(Address) 12 Church Rd

15 Filed NOV 1 0 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Insufficiency

Some Time (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

Some Time (duration) yrs. mos. ds.

(Signed) A. Riley, M. D. (Coroner.)

Nov. 10, 192 4 (Address) 1639 Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 4 or 5 mos

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL Nov. 11 192 4

20 UNDERTAKER Frank Czaczka

ADDRESS 1916 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT J. KRAUTER
Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91838

CERTIFICATE OF DEATH.

113 D 91838

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard or Greene ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Humm (Bernard Merrill Humm)

(a) RESIDENCE No. 928 W Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Infant

6 DATE OF BIRTH (month, day, and year) June 8, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		5 mo	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Infant —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry E. Humm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick County Maryland

12 MAIDEN NAME OF MOTHER Lilly May Gilliss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll County Maryland

14 Informant Harry E. Humm

(Address) 928 W. Lombard Street

15 NOV 10 1924 ROBERT A. KRAUTH, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9- 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 17- 1924 to 11-9 1924.

that I last saw him alive on 11-9 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia - Diarrhea.

6 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Slom Jr M. D.

11-10 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Nov. 11 1924

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91839

CERTIFICATE OF DEATH.

D 91839

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2705 Westwood Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edna C. Snyder

(a) Residence No. 2705 Westwood Avenue St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Snyder

6-DATE OF BIRTH (month, day and year) Sept. 15, 1889

7-AGE. 35 yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER Howard K. Scott

11-BIRTHPLACE OF FATHER (city or town)... Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Lina Starker

13-BIRTHPLACE OF MOTHER (city or town)... Baltimore Co
(State or Country), Maryland

14- (Informant) William W. Snyder
(Address) 2705 Westwood Avenue

15- Filed NOV 10 1924 ROBERT F. KRAUTER, Registrar.
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5 1924, to Nov. 9, 1924, that I last saw h[er] alive on Nov. 9, 1924, and that death occurred, on the date stated above, at 10.45 m. A

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Whitehouse, M. D.

11-10 1924 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL, Nov. 11 1924

20-UNDERTAKER Jos B Cook — ADDRESS 1003 Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91840

CERTIFICATE OF DEATH.

1 3 D 91840

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Butterworth (Raymond Louis Butterworth)

(a) RESIDENCE NO. 848½ W. Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): May 27, 1924

7 AGE: Years | Months 5 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: George B. Butterworth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Theresa Gosewisch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co. Maryland

14 Informant: University Hosp. Records.

(Address)

15 Filed NOV 10 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 10, 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-7-, 1924, to 11-10, 1924.

that I last saw him alive on 11:30-, 1924,

and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis -

Diarrhea

Intestinal toxemia -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Marasmus -

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Edwards M. D.

11-10 19 24 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Nov. 12 1924

20 UNDERTAKER: Jos. B. Cook — ADDRESS: 1038 Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91841

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2531 Shirley Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Tilyard Packham

(a) Residence No. 2531 Shirley Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert E. Packham

6-DATE OF BIRTH (month, day and year) April 26 1894

7-AGE.	If LESS than 1 day.
30 yrs. 6 mos. 14 ds.	...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore (State or Country): Maryland

PARENTS.

10-NAME OF FATHER. Charles A Tilyard

11-BIRTHPLACE OF FATHER (city or town): Baltimore (State or Country): Maryland

12-MAIDEN NAME OF MOTHER. Nora Greenfield

13-BIRTHPLACE OF MOTHER (city or town): Balto Co. (State or Country): Maryland

14- (Informant) Robert E. Packham

(Address) 2531 Shirley Ave.

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 9" 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8— 1924 to Nov 9— 1924, that I last saw h[illegible] alive on Nov. 8— 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Embocardities Cerebro Meningitis

about 3 days

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

about 12 years

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) Carlton McCook M. D.

Nov 9 - 1924 (Address) 7219 St Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Druid Ridge	Nov 11 1924
20-UNDERTAKER Ralph B. Cook	ADDRESS 1003 W. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 91842

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 231 S. Calhoun Street St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Catherine McManus

(a) Residence No. 231 S. Calhoun Street St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 26, 1923

7-AGE. 1 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John Martin McManus

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Lillian Catherine Goonan

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country). Maryland

14- (Informant) John Martin McManus

(Address) 231 S. Calhoun St.

15- Filed....., 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17....., 19 24, to Nov. 7/24, 19....., that I last saw h.er alive on Oct. 7, 1924, 19....., and that death occurred, on the date stated above, at 5.5 A m.

The CAUSE OF DEATH* was as follows:

Acute miliary tuberculosis

.....(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

.....(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical

(Signed) Edward Cookman, M. D.

11-7, 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Calvary Cem. DATE OF BURIAL, Nov 10 19 24

20-UNDERTAKER. Joseph D. Cook ADDRESS 1003 N. Fulton Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91843

CERTIFICATE OF DEATH.

D 91843

45

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3003 Alameda Boulevard (ST.) 9 (WARD)

2-FULL NAME Mrs H. E. Hopkins

(a) RESIDENCE. No. 3003 Alameda Blvd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 62

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk at 109

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Mrs H. E. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose E. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Lloyd A. Spicer

(Address) 3003 Alameda Blvd

15 Filed ... 19...

NOV 10 1924

ROBERT J. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Nov 9, 1924, that I last saw him alive on Nov 9, 1924, and that death occurred, on the date stated above, at 9:15 P.m.

The CAUSE OF DEATH* was as follows:

Cancer of the Mesenteries.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hemia (duration) yrs. 2 mos. ds.

18 Where was disease cuntracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

11/10/24 (Address) 2855 Harford St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 11/12 1924

20 UNDERTAKER Philip Henry Adams — ADDRESS 2016

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 91844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 91844

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Eastern Ave 29th St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meisenhalder

(a) Residence No. Eastern Ave 29th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred. Meisenhalder

6-DATE OF BIRTH (month, day and year) Nov 9th 73

7-AGE. 50 yrs. 11 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country) Md

PARENTS.

10-NAME OF FATHER George H. Seely

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Anna E Stenneth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Fred Meisenhalder

(Address) Eastern Ave 29

15- NOV 1 0 1924 ROBERT A. KRUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 7th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924 to Nov. 7 1924

that I last saw h[illegible] alive on 11 3 1924

and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Paralisis Hemorrhage of Brain

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn, M. D

11/9, 1924 (Address) 970 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel — DATE OF BURIAL. 11/10 1924

20-UNDERTAKER. Phil. Herrig — ADDRESS 2016 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91845

CERTIFICATE OF DEATH.

D 91845

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 628 N. Belnord Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Morris

(a) Residence No. 628 N. Belnord Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Barbara Morris

6-DATE OF BIRTH (month, day and year) Mar 20 58

7-AGE. 66 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rigger

(b) General nature of industry, business, or establishment in which employed (or employer) Ship

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), [illegible] N. J.

PARENTS.

10-NAME OF FATHER, Harry Morris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary E

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Barbara Morris

(Address) 628 N. Belnord

NOV 10 1924

ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 9/24

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924 to Nov 7 1924 that I last saw h[illegible] alive on Nov 6 1924 and that death occurred, on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Gastric & Hepatic Carcinoma

(Duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical 3 weeks

(Signed) Johns Hopkins Hospital M. D.

Nov 9. 1924 (Address) Cold Spring Lane

*State the Disease Causing Death, or in Deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL. 11/11 1924

20-UNDERTAKER, Philip Herwig — ADDRESS 2016 Orleans St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91846

CERTIFICATE OF DEATH.

118 1902

D 91846

1-PLACE OF DEATH Hebrew Hospital.

CITY OF BALTIMORE: (No. Monument St & Rutland Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albertina Williams.

(a) RESIDENCE NO. 1206 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Williams

6 DATE OF BIRTH (month, day, and year) Oct 26 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Victor Voegtlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Emelia L. Voegtlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Marguerite Williams

(Address) 1206 Bolton St.

NOV 10 1924

ROBERT P. KRAUTH

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 10/17, 1924 to 11/8, 1924,

that I last saw her alive on 11/8, 1924

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction,

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 10/20/24; 10/24/24

Was there an autopsy? Yes (1) Removal of cyst (2) Colostomy

What test confirmed diagnosis?

(Signed) Philip Jacobson, M. D.

. 19 (Address) 1 Belmont Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/11 1924
20 UNDERTAKER	ADDRESS
Chas. E. Evans & Son	1011 W. Mt. Royal Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91847.

CERTIFICATE OF DEATH.

D 91847.

Registered No.....

1-PLACE OF DEATH Church Home Infirmary 6 St., Ward)

City of BALTIMORE: (No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Eby

(a) Residence No. York Pa St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced—HUSBAND of (or) WIFE of Benjamin Eby

6-DATE OF BIRTH (month, day and year) Dec. 1 1898

7-AGE. 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) York Pa (State or Country),

PARENTS.

10-NAME OF FATHER, J. H. Richley

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Katie Brandt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Benjamin M. Eby

(Address) 630 York St. York Pa

15- Filed ..... 1924 ROBERT F. KRAUTER, Registrar.

Burial Permit Clerk.

NOV 10 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1924 to Nov. 10 1924, that I last saw her alive on Nov. 10 1924, and that death occurred, on the date stated above, at 7 15 A.m.

The CAUSE OF DEATH* was as follows:

Ulcerative Colitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhages (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? York, Pa.

Did an operation precede death? Yes Date of Nov. 5, 1924

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) Kurt H. Rice M. D.

19 (Address) Church Home + Infirmary Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL York Pa

DATE OF BURIAL, Nov 10, 1924

20-UNDERTAKER, Joseph Adrems

ADDRESS 221 Bway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91848

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2542 Guilford Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E Worich

(a) RESIDENCE No. 2542 Guilford Ave ST., 17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Worich

6 DATE OF BIRTH (month, day, and year) Aug 16, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Worich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Alexander Worich
(Address) 2542 Guilford Ave

Filed NOV 7 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Glorus, M. D.
(Coroner.)
Nov 7th, 1924 (Address) 2032 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Nov 10 1924

20 UNDERTAKER W. M. Cook ADDRESS 1022 E Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91849

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Harlem ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard F Fowler

(a) RESIDENCE No. 721 Harlem ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Florence Underwood Fowler

6 DATE OF BIRTH (month, day, and year) Mar 15 /87

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) don't know in Chicago 63

(c) Name of employer don't know

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Richard F. Fowler

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha J. Chard

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs Martha J Fowler (Address) 721 N. Wolfe ave

15 Filed NOV 10 1924 19 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1924, to Nov 7, 1924, that I last saw him alive on Nov 6, 1924, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Spinal cerebral syphilis

Nov 6 (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis bladder & Convulsions (duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? in U. S. Navy

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wassermann

(Signed) H E Knight, M. D.

Nov. 1924 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Nov 10 1924

20 UNDERTAKER W. M. Roulson — ADDRESS 2238 N Mott

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91850

CERTIFICATE OF DEATH.

27 X 43

D 91850

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5016 Catalpha Rd. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Francis A. Phillippi.

(a) Residence No..... 5016 Catalpha Rd. St., ... Ward..... Pottstown Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married.

5a-If married, ~~widowed, or divorced~~ HUSBAND of ~~Deceased~~ Mary A. Phillippi.

6-DATE OF BIRTH (month, day and year) Dec. 26, 1850.

7-AGE, ..73.. yrs. ..10.. mos. ..14.. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Pattern Maker.

(b) General nature of Industry, business, or establishment in which employed (or employer)..... D86

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Reading, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Abraham Phillippi.

11-BIRTHPLACE OF FATHER (city or town)... Reading, (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Mary Levering.

13-BIRTHPLACE OF MOTHER (city or town)... Phila. (State or Country), Pa.

14- (Informant)... Mary A. Phillippi, (Wife)

(Address)..... 5016 Catalpha Rd.

NOV 10 1924 ROBERT J. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24 to Nov 9, 19 24

that I last saw h.. alive on Nov 9, 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the tongue

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of the tongue

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Long, M. D.

Nov 10, 1924 (Address) 2718 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pottstown Pa. DATE OF BURIAL, Nov. 11, 1924.

20-UNDERTAKER, A. Howard Evans ADDRESS 38 E. FORT Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175-D 91851

100-001

D 91851

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

2-FULL NAME Doris O'Connor

(a) RESIDENCE NO. 2341 Lyndale Ave. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —"—

(c) Name of employer ..... —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward O Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Scullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 NOV 10 1924 ROBERT A. KRAUTH Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924, to Nov 9, 1924, that I last saw her alive on Nov 9, 1924, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary) Thrush — 8 days
Bronchopneumonia

(duration) yrs. ..... mos. ..... 4 ds.

18 Where was disease contracted if not at place of death? Home + in Hosp.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Edmund H. Kerper, M. D.

Nov 9, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakeview Cemetery	Nov 10th 1924

20 UNDERTAKER J. J. Moran ADDRESS 1st & Bank St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400, Bks.

D 91852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 91852

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hosp St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William N. Wadley

(a) Residence No. 2303 Fairmount Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 10-1903

7-AGE. 21 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Wm Wadley

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Bit

PARENTS.

10-NAME OF FATHER. Wm Wadley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bit

12-MAIDEN NAME OF MOTHER. Martha Gregory

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bit

14- (Informant) Wm Wadley

(Address) 2303 Fairmount Ave

15- Filed ..... 192 ..... Registrar.

NOV 1 01924 ROBERT R. KRAUSE

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-8-24.

17- I HEREBY CERTIFY, That I attended deceased from 10-25 1924 to 11-8 1924

that I last saw him alive on 11-8 1924

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction - Hydrocele Strangulated inguinal hernia - secondary obstruction

(Duration) yrs. mos.

18-Where was disease contracted, if not at place of death? 2303 Fairmount Ave

Did an operation precede death? 2 Date of 10/27/24 11/7/24

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Dybert M. D.

, 19 (Address) St Josephs Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Londonderry Cem

DATE OF BURIAL. Nov. 11th 1924

20-UNDERTAKER. J. A. Moran

ADDRESS 3008 E. Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91853

CERTIFICATE OF DEATH.

10

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 17 WARD)

2-FULL NAME Robert Edward Stup

(a) RESIDENCE NO. 2816 Huntingdon Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Neale Stup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Clara May Ruby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Wm N Stup
(Address) 2816 Huntingdon Ave

15 Filed NOV 10 1924 ROBERT N. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1924, to Nov. 10, 1924, that I last saw him alive on Nov. 10, 1924, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pos. K.L culture

(Signed) Myron B Tuell, M. D.

11/10, 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 13, 24

20 UNDERTAKER Chenoweth & Son ADDRESS 364 Chestnut Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91854 HEALTH DEPARTMENT—CITY OF BALTIMORE. 16-D 91854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary Registered No.

City of BALTIMORE: (No. Broadway & Fairmount Ave 22 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gloriose

(a) Residence No. 222 S. Paca St. St., Ward

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 9, 1924

7-AGE. yrs. mos. ds. If LESS than 1 day, hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Robert Gloriose

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Sadie Ranzino

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14-(Informant) Robert Gloriose

(Address) 223 S. Paca St. 10/1

15-Filed NOV 10 1924, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 9-24

17- I HEREBY CERTIFY, That I attended deceased from November 9 1924 to November 9 1924

that I last saw h[illegible] alive on November 9 1924

and that death occurred, on the date stated above, at 6:10 A.M.

The CAUSE OF DEATH* was as follows:

Measles.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? YES

What test confirmed diagnosis?

(Signed) John E. Norment M.D.

, 19 (Address) Church Home & Infir.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL DATE OF BURIAL, , 19

20-UNDERTAKER. ADDRESS. NOV 10 1924

NOV 10 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bbs.

D 91855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91855

CERTIFICATE OF DEATH.

REGISTERED NO. 3 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S Caroline ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Lloyd

(a) RESIDENCE NO. 308 S Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Lloyd

6 DATE OF BIRTH (month, day, and year) Aug 8, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	80	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Pensioner)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mollie Lloyd (Address) 308 S Caroline St

15 Robert P. Harrison, Registrar

. 19 Burial Permit Clerk.

NOV 1 0 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6 1924 to Nov 7 1924, that I last saw h alive on Nov 7 1924, and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2/0 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Harris, M. D.

. 19 (Address) 38 S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Nov. 11 1924

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1726 Ashland Ave

W.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91856

CERTIFICATE OF DEATH.

REGISTERED NO. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Telman David Laffermen

(a) RESIDENCE NO. 1101 Woodyear St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Sam Laffermen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Windsor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hosp Records
(Address) Robert P. Harriman,

15 NOV 10 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1924, to Nov 9, 1924,

that I last saw him alive on Nov 9, 1924,

and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Anaphylactic Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Given 10cc Antistreptococcic Serum Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G Tull, M. D.

11/10 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	11-10-1924
20 UNDERTAKER	ADDRESS
Fact Lyon	1439 E Balto

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91857

D 91857

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 Woodlawn Road St. Roland Park WARD)

2-FULL NAME Laura Alexander Wood

(a) RESIDENCE NO. 318 Woodlawn Road Roland Park WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of George Wisner Wood

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Huntsville, Ala.

PARENTS

10 NAME OF FATHER John Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Softley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. George H. Campbell
(Address) 214 Ridgewood Rd. Roland Park

15 Filed 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

V 1 0

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6th, 1924, to Nov. 9th, 1924, that I last saw her alive on Nov 9th, 1924, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart
(Brain in compensation)

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Van Arsdale, M. D.

11/10, 1924 (Address) 1515 Mass Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood Cem New York

DATE OF BURIAL Nov 10 1924

20 UNDERTAKER Henry W Jenkins & Co

ADDRESS Oakland Md

NOTE—WHITE PEARL, WHITE ENAMEL RECORD. EVERY question should be carefully answered and the information supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. ARMY MEDICAL DEPARTMENT

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91858

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Drury Lane Ten Hills St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dorthea Manger Platt

(a) Residence No. Drury Lane Ten Hills St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 18, 1862

7-AGE. 62 yrs. 3 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore

(State or Country). Md

PARENTS.

10-NAME OF FATHER. George Nathan Manger

11-BIRTHPLACE OF FATHER (city or town).

(State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Beck

13-BIRTHPLACE OF MOTHER (city or town).

(State or Country). Germany

14- (Informant) Dr. William P. Platt

(Address) Drury Lane Ten Hills Baltimore Md

15- Filed NOV 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/1/24

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to Nov 7, 1924

that I last saw h.. alive on Nov 9, 1924

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast, with metastasis to Lungs.

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Here

Did an operation precede death? Yes Date of Dec 5/1923.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. P. Platt, M. D.

, 19 24 (Address) 504 Cath. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem

DATE OF BURIAL, Nov 1, 1924

20-UNDERTAKER. George I Smith

ADDRESS 1532 Hollins St

OV 1 1924

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91859

D 91859

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Aged Home M. E. Church

City of BALTIMORE: (No. 400 N. Fulton Ave. St., 70 Ward) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Laura Hetzell Aged Home M. E. Church

(a) Residence No. 400 N. Fulton St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1849

7-AGE. 75 yrs. 8 mos. 27 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. William Storm

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll Co Md

12-MAIDEN NAME OF MOTHER. Sarah Storm

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carroll County Md

11- (Informant) Etta Lemmon

(Address) 400 N. Fulton

15- Robert P. Harrison Registrar.

NOV 10 1924

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 9. 1924

17- I HEREBY CERTIFY, That I attended deceased from October 15 1924 to Nov 9 1924

that I last saw h.... alive on Nov 8 1924

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. 27 ds

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Shannon M. D

11/10. 1924 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL, Nov 11 1924

20-UNDERTAKER. George J Smith

ADDRESS 153 Hollins st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91860

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

2-FULL NAME Rev. Matthew Davis

(a) RESIDENCE NO. 1832 North 22nd. ST. Philadelphia, Pa. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) 018
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va.

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Rev. J. W. McCoy 1124 Bentz ave.

Robert P. Harrison, Registrar
Burial Permit Clerk.

V 1 0 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1924 to Nov. 10, 1924.

that I last saw him alive on Nov. 10, 1924,

and that death occurred, on the date stated above, at 4:35 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. White M. D.

, 19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila. Pa.	Nov. 10, 24
20 UNDERTAKER Samuel Hemsley	ADDRESS 1118 Druid Hill Ave

B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View Asylum St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Benjamin Taylor

(a) Residence No. 1016 Mc Culloch St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, ~~Divorced~~. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879.

7-AGE. 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Reuben Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Hospital Records.

(Address) Bay View Hospital.

15- Robert P. Harrison, 192.....
Registrar.

NOV 10 1924
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 7-24.

17- I HEREBY CERTIFY, That I attended deceased from Nov 6, 1924, to Nov 7, 1924.

that I last saw h[illegible] alive on Nov 7 1924.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Multiple Urethral Structures 25 yrs. (gonorrheal) Urinary extravasation on Abdominal wall, Anuria, Uremia & Sepsis

(Duration) ..... yrs. ..... mos. 11. ds.

CONTRIBUTORY (Secondary) Toxemia from Urinary

Gangrene (Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death? 1016 Mc Culloch St

Did an operation precede death? yes Date of 10-7-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. Tests

(Signed) Dr. P. Claude Jr., M. D.

19 Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 192
Mt Auburn Cem	11-17-24
20-UNDERTAKER	ADDRESS
Chas Easton	916 Ca ons

Date Burial 11/12/24.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. (Joseph H. Peters)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91862 D 91862

CERTIFICATE OF DEATH.

Registered No. 74-806

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Peters, Joseph H.

(a) Residence No. 534 W. Hoffman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rebecca Peters

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Porter

(b) General nature of industry, business, or establishment in which employed (or employer). 0/0

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Joseph Rezin, (Address) Bay View Hospital

15- Filed NOV 10 1924 192 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-8-24

17- I HEREBY CERTIFY, That I attended deceased from 5/15/ 1924 to 11/8/ 1924 that I last saw him alive on 11/7/24 1924 and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Terminal acute nephritis.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension ?

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? Clinical & Lab. findings

What test confirmed diagnosis?

(Signed) H. Fredowitz M. D.

, 19 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem DATE OF BURIAL. 11-10-24, 192

20-UNDERTAKER. Daniel Easton ADDRESS 916 Gorman Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91863 D 91863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. University Hospital ST., 4 WARD) REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno Bell

(a) RESIDENCE No. 600 Pine St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colr	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborr.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Willie L Lewis (Address) 600 Pine St

15 Filed ..., 192 Robert P. Harrison, Registrar

V 1 01924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said (Inquest, autopsy ~~or inquiry~~) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound in abdomen a few hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shot by some person at the

(duration) yrs. mos. ds.

(Signed) W R Jamison, M. D.

(Coroner.)

11-10, 192 (Address) 1127 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL 11 12 24

20 UNDERTAKER David Eastman — ADDRESS 912 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 91864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91864

CERTIFICATE OF DEATH.

181-9101

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1456 Montpelier St ST., 9 WARD)

2-FULL NAME Mary Elizabeth Hopper

(a) RESIDENCE NO 1456 Montpelier St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Morris E. Hopper

6 DATE OF BIRTH (month, day, and year) April 1/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John W. Latourna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie M. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Morris E. Hopper
(Address) 1456 Montpelier St

Filed ..... 192 ..... Registrar

OV 1 0 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hydcardial Insufficiency-acute dilatation -Odema & congestion of lungs (Autopsy by Dr. Maldeis)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Inhalation of farmaldehyde gas. (over)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mallen, M. D.
(Coroner.)

Nov 9/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 11 1924

20 UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Fremont Ave

MATTER should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 91865 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 91865

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 137 W Hill St., 77 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Spence

(a) Residence No. 137 W Hill St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible] 1861

7-AGE. 63 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Day Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Isaac Spence

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Julia [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Owen Spence

(Address) 137 W Hill St

NOV 11 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 29, 1924 to Nov 8 1924

that I last saw h[illegible] alive on Nov 8 1924

and that death occurred, on the date stated above, at 11.30p m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? uranalysis

(Signed) H S McCard M. D.

11/10, 1924 (Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Zion — DATE OF BURIAL. Nov 12 1924

20-UNDERTAKER John H Tradin — ADDRESS 1027 Druid Hill Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91866

CERTIFICATE OF DEATH.

46 D 91866

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Ethrig ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Brown

(a) RESIDENCE NO. 1703 Ethrig ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Brown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Household

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Daniel Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ashley Reed

(Address) 1703 Ethrig St

15 Filed NOV 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1924

17 Oct 20th

I HEREBY CERTIFY, That I attended deceased from Oct 20th, 1924, to Nov. 7th, 1924, that I last saw h— alive on Nov. 6th, 1924, and that death occurred, on the date stated above, at 2'40 a.m.

The CAUSE OF DEATH* was as follows:

Accident

(duration) yrs. mos. 7d ds.

CONTRIBUTORY (Secondary) Pronchopneumonia

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Feb 4, 23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Bell, M. D.

19 (Address) 1703 Ethrig St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Nov 11, 1924

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91867

38 D 91867

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq Hospital (St.) 23 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Wyatt

(a) RESIDENCE NO. 1025 Plum ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE 55 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Va

PARENTS

10 NAME OF FATHER Robt Wyatt

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Adelaide Jones

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Ellen W Tate
(Address) 636 Pine Valley

NOV 1 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-1924

17 I HEREBY CERTIFY, That I attended deceased from 10-25-, 1924, to 11-10-, 1924, that I last saw him alive on 11-10-, 1924, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

(1) Chronic Interstitial nephritis

(a) Testing Syphilis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Laboratory Exam,

(Signed) N. T. Parr, M. D.

(Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery | DATE OF BURIAL 11-11 1924

20 UNDERTAKER Harlan A. Holland | ADDRESS 1631 W. Pratt

Spec—12-23-2t—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91868

CERTIFICATE OF DEATH.

129 D 91868

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 S. Luzerne Ave., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Welzel

(a) Residence No. 514 S. Luzerne Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Welzel

6-DATE OF BIRTH (month, day and year) Nov. 25, 1878

7-AGE. 45 yrs. 11 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Porsch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14-(Informant) Charles Welzel

(Address) 514 S. Luzerne Ave

15- NOV 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 9. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Nov 9, 1924, that I last saw h[illegible] alive on Nov 9, 1924, and that death occurred, on the date stated above, at 9 12 A. m.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart,

Chronic Diffuse Nephritis

(Duration) yrs. mos. 1 yr ds.

CONTRIBUTORY (Secondary) Uterine fibroma

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) [illegible] M. D.

11/13/24 1924 (Address) 1623 E Pratt St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
1st Evangelical Cemetery	Nov. 11, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander & Sons	1710 Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 91869 — 1 PLACE OF DEATH — REGISTERED NO. D 91869

CITY OF BALTIMORE (No. 2813 Pennsylvania Ave St.; 13 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Albert H. Schanze Sr.

(Residence in Baltimore: No. 2813 Pennsylvania Ave St.; 67 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan 22, 1857 (Month) (Day) (Year)

7 AGE: 67 yrs. 9 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Clerical work Office (b) General nature of industry, business, or establishment in which employed (or employer): 109

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. Schanze

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Katherine Schmidt

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred. Schanze

(Address) 2813 Parkwood

15 Filed NOV 11 1924, 191 ROBERT A. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 10 (Month) (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 191 to Nov 10 1924 that I saw h[illegible] alive on Nov 9, 1924 and that death occurred on the date stated above, at 1.05 m.

The CAUSE OF DEATH* was as follows: [illegible] Carcinoma Abdomen Chronic Valvular Myocarditis 5

(Duration) 5 yrs. mos. ds

Contributory (SECONDARY) [illegible]

(Duration) yrs. mos. ds.

(Signed), Edward Barber M. D.

, 191 (Address) 2731 Parkwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 11, 1924

20 UNDERTAKER: James Bowers Sons — ADDRESS: 901 Hollins St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91870

CERTIFICATE OF DEATH.

D 91870

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., (WARD)

2-FULL NAME Charles F. Weber

(a) RESIDENCE No. Elkridge, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? 48 yrs. 2 mos. 27 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Weber

6 DATE OF BIRTH (month, day, and year) Aug 4th 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Constable
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fredrick Gill
(Address) Elkridge, Md

15 Filed ..... 192 ..... Registrar

NOV 1 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 — 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock — 2nd 7-8-9 D

Ribs fractured on left side D

also fractured Sternum D

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Auto Accident

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.

Nov 10 — 192 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westlakeleen Elkridge Md	Nov. 13 — 192
20 UNDERTAKER John J. Conway & Son P. J. F. Conway	ADDRESS 301 Park Ave

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91871

CERTIFICATE OF DEATH.

1924 D 91871

1-PLACE OF DEATH Found in Water

CITY OF BALTIMORE: (No. 1007 Lancaster ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Goldie Howard Robinson

(a) RESIDENCE NO. 3784 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Robinson Cubas

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Lawrence Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Robinson
(Address) 3784 Mount St

15 NOV 11 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found in water Nov 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James McPherson, M. D.
(Coroner)

Nov 11 1924 (Address) 100 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — DATE OF BURIAL: Nov 11 1924

20 UNDERTAKER: Wm P. C. Ellis — ADDRESS: 2 Eastland

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 91872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 91872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Molloy

(a) RESIDENCE NO. Bay View Asylum ST., WARD Patterson.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ the late Rose Molloy

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ~~O~~ None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 Filed NOV 1 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-2, 1924, to 11-10, 1924

that I last saw him alive on 11-9, 1924

and that death occurred, on the date stated above, at 4.40 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sub. + Autopsy

(Signed) Claude S. Drane, M. D.

11-10, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cindy	Nov 10 1924
UNDERTAKER	ADDRESS
Jas. A. Millet & Son	2334 Jeff

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91873

CERTIFICATE OF DEATH.

74-001

D 91873

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial ST., 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F Bayly

(a) RESIDENCE NO 1006 Falls Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Grace D. Bayly

6 DATE OF BIRTH (month, day, and year) Dec 24 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	42	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) W. M Ry
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER William F Bayly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Ella Coban

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant William F Bayly
(Address) 1006 Falls Rd

NOV 11 1924

ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the date stated above. (Inquest, Autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Shotgun

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Norman M. D.
Coroner.

Nov 10, 1924 (Address) 3532 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Pa — DATE OF BURIAL Nov 12 1924

20 UNDERTAKER A S Marshall 3539 Falls Rd — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 91874

D 91874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 W. Washington

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Mattfeldt ST., 37 WARD)

2-FULL NAME George N. Wilson

(a) RESIDENCE NO. 32 Mattfeldt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (c:) ~~Wife of~~ HUSBAND of Mary C Wilson

6 DATE OF BIRTH (month, day, and year) 7-4-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Walter W. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Wilson
(Address) 129 W Washington Ave

15 NOV 7 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Nov. 9, 1924,

that I last saw him alive on Nov 9, 1924,

and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis - Chronic Bright's Apoplexy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary tests

(Signed) C. H. Beetem, M. D.

11-10, 1924 (Address) 129 W Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 12 1924
20 UNDERTAKER	ADDRESS
P S Marshall 3538	Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 91875

HEALTH DEPARTMENT—CITY OF BALTIMORE

80 D 91875

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2797 Cedar ave ST., 13 WARD)

2-FULL NAME Earl L. Penner

(a) RESIDENCE NO. 2797 Cedar ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 15 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Elmer Penner

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Vermillion

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Elmer Penner
(Address) 2797 Cedar Ave

15 NOV 11 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest I find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Abscess

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Carrion, M. D.
(Coroner.)
Nov 11 1924 (Address) 2692 Rutland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 11 1924

20 UNDERTAKER Chenowith Bros ADDRESS 361 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91876

CERTIFICATE OF DEATH.

90

D 91876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 E Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Theresa Hall

(a) RESIDENCE NO. 2208 E Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Hall

6 DATE OF BIRTH (month, day, and year) May 5, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frances Hall

(Address) 2208 E Fayette St

15 NOV 11 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 19 24, to Nov 9, 19 24.

that I last saw h[illegible] alive on Nov 9, 19 24

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Evs

(Signed) J C Hades, M. D.

. 19 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL Nov 12 1924

20 UNDERTAKER J. M. Cook — ADDRESS 502 E Lafayette Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wm Sadtler Jr

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 91377

CERTIFICATE OF DEATH.

D 91377

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3529 Eutaw Place ST.: N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sadtler Jr.

(a) RESIDENCE. NO. 3529 Eutaw Place WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): Nov. 3 1924

7 AGE: Years | Months | Days: 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John. Sadtler.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna. Eck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John. Sadtler. (Address) 3529 Eutaw Place

15 Filed ..... 19.....

NOV 11 1924

ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-10 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-3 1924 to 11-10 1924

that I last saw h[illegible] alive on 11-9 1924

and that death occurred, on the date stated above, at 11 50 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Immature)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Finding

(Signed) Fred Rogers M. D.

19[illegible] (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem. DATE OF BURIAL: Nov 19[illegible]

20 UNDERTAKER: Wendell J. Hippel ADDRESS: 37 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91878 HEALTH DEPARTMENT—CITY OF BALTIMORE

160 D 91878

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2708 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lawrence Jakimowski

(a) Residence No. 2708 Elliott St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 24-1924

7-AGE, ...yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Leon Jakimowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Martha Stanuchis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Leon Jakimowski

(Address) 2708 Elliott St

NOV 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov-9-1924

17- I HEREBY CERTIFY, That I attended deceased from Novemb 7. 1924 to Novemb 9 1924

that I last saw him alive on Nov-9 1924

and that death occurred, on the date stated above, at 6.45 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bronushas, M. D.

11-10. 1924 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Stanislaus Cem — DATE OF BURIAL, Nov 11 1924

20-UNDERTAKER, Stephen J Fialkowski — ADDRESS 1005 Kenyon

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91879

CERTIFICATE OF DEATH.

74-001 D 91879

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1841 Mc Henry St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Resh

(a) Residence No. 1841 Mc Henry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelius Resh

6-DATE OF BIRTH (month, day and year) June 10th 1838

7-AGE, 86 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Albon

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Carroll Co. Md

12-MAIDEN NAME OF MOTHER, Mary Kelbaugh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Carroll Co. Md.

14- (Informant) John G. Albon

(Address) 1841 Mc Henry 26

15- NOV 11 1924 ROBERT P. LAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924, to Nov. 10, 1924

that I last saw h.e.r. alive on Nov. 10, 1924,

and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. & Hist.

(Signed) Thomas Linder, M. D.

, 19 (Address) 1704 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Lorelei Cem., Carroll Co. Md. DATE OF BURIAL, Nov. 11, 1924

20-UNDERTAKER Geo. L. Schwab ADDRESS 210 Fulton Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91880

CERTIFICATE OF DEATH.

74-001

D 91880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Brunt St., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Gross

(a) RESIDENCE No. 2206 Brunt St.; WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Gross.

6 DATE OF BIRTH (month, day, and year) about 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Annie Collins
(Address) 2206 Brunt St.

15 NOV 11 1924 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no autopsy

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Nov. 10, 192 4 (Address) 28 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 10/11 1924

20 UNDERTAKER Samuel D. Hensley

ADDRESS 1118 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 91831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 91831

REGISTERED NO. D 91831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Etting St. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Jefferson

(a) RESIDENCE NO. 1315 Etting St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Jefferson

6 DATE OF BIRTH (month, day, and year) about 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Bracevon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James Jefferson (Address) 1315 Etting St

15 Filed NOV 11 1924, 192 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jur (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos 1 hr ds.

CONTRIBUTORY (Secondary) History

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Nov. 9 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 10/11 1924

20 UNDERTAKER Samuel J. Hemsley

ADDRESS 578 N Eddie

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 91882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91882

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 624 W Saratoga ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edard

(a) RESIDENCE NO. 624 W Saratoga ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): unknown 1888

7 AGE: Years 36; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: Driving truck

(b) General nature of industry, business, or establishment in which employed (or employer): Chauffeur

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Patterson Md

PARENTS

10 NAME OF FATHER: Richard Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lydia McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore County

14 Informant (Address): Mrs Mary Mc McCann 1707 Division St

15 Filed NOV 1 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-8-1924

17 I HEREBY CERTIFY, That I attended deceased from 11/5, 1924, to 11/8, 1924, that I last saw h[illegible] alive on 11/8, 1924, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Heart Failure

Mellitus

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. [illegible] Jackson M. D.

19 (Address) 808 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether (Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 10/11 1924

20 UNDERTAKER: Samuel D Heusler

ADDRESS: Middle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1613 S. Charles St., 7 Ward)

Registered No. 101-001 D 91883

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline E. Heing

(a) Residence No. 1613 S. Charles St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Heing

6-DATE OF BIRTH (month, day and year) Feb. 5. 1853

7-AGE, 31 yrs. 8 mos. 20 ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md.
(State or Country)

PARENTS.

10-NAME OF FATHER, Adolph Mackenroth

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Elizabeth Hufsfeldt

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14- (Informant) John A. Heing

(Address) 1613 S. Charles St

15- Filed ... 192... ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 4, 1924 to Nov 8, 1924 that I last saw h[illegible] alive on Nov 8, 1924 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Edema Pneumonia & Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. 1 mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Kneisner M. D.

11 10, 1924 (Address) 1 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cem. DATE OF BURIAL, NOV 11 1924

20-UNDERTAKER, Margaret L. Flynn ADDRESS 172 Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

17605 2

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91884

CERTIFICATE OF DEATH.

D 91884

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME John B. Young

(a) RESIDENCE NO. Richmond, Va ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann G. Young

6 DATE OF BIRTH (month, day, and year) April 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnish Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John B. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 11 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/5/24, 1924, to 11/11/24, 19....., that I last saw him alive on November 10th 1924, and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

General Metastasis

Intestinal Obstruction

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Richmond Virginia

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Lee Lamb, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond, Va — DATE OF BURIAL Nov 12 1924

20 UNDERTAKER John B. Spence 325 N. Eden St. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001

D 91885
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Fleet ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances P Mokracka

(a) RESIDENCE NO. 2407 Fleet ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P Mokracka

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin Can Manufacturing

(b) General nature of industry, business, or establishment in which employed (or employer) Bayle Can Co

(c) Name of employer Bayle can co 046

9 BIRTHPLACE (city or town) (State or country) Puntan N J

PARENTS

10 NAME OF FATHER John Jakwaska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Swanlowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant James P Mokracka
(Address) 2407 Fleet st

15 NOV 11 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 19 24, to Nov 10, 19 24, that I last saw h[illegible] alive on Nov 10, 19 24 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage following
Perforation of Stomach
Ulcer

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Ulcer of Stomach
Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Signs

(Signed) Samuel L Snakes, M. D.

1924 (Address) 3325 Pattpt a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL NOV. 17, 1924.

20 UNDERTAKER M. F. Sadowski

ADDRESS 700 L. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 91886 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91886

58-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 312 S. Bouldin St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Einersen

(a) Residence No. 312 S. Bouldin St., 26 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward A Einerson

6-DATE OF BIRTH (month, day and year): Aug. 15 1869

7-AGE: 55 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: ...

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Michael Wolfersman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret M Tattu

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11- (Informant): Edward A Einerson

(Address): 312 S. Bouldin St.

15- NOV 11 1924 ROBERT B. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 9th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1924 to Nov 9 1924

that I last saw h.. alive on Nov 9 1924

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Picture

(Signed) Carl Schneider M. D

11/10 1924 (Address) 2939 Easterwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cemetery	Nov 12 1924
20-UNDERTAKER.	ADDRESS
Lilly & Geiler	408 W Saratoga St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 91887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 91887.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Hunting Ave. St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Carl Reynolds

(a) RESIDENCE. No. 2601 Huntingdon Ave St., 12 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 5 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Marshall Reynolds

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Stump.

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Marshall Reynolds
(Address) 2601 Huntingdon Ave

15 NOV 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1924.

17

I HEREBY CERTIFY, That I attended deceased from Oct 5 . 1924 . to Nov 10 . 1924.

that I last saw h— alive on Nov 10 . 1924.

and that death occurred, on the date stated above, at 8.11 a. m.

The CAUSE OF DEATH* was as follows:

Congenital weakness due to premature birth. Twin (Child weight 3 lbs + 8 oz)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Rebt Norment M. D.

11.11. 1924 (Address) 3343 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harlem Cemetery	11/11/24 19

20 UNDERTAKER Geo. Weber & Son

ADDRESS 2503 Edmondson Ave

Cor.—1-12-23—M&T—100 Bks.

Wischer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91888

CERTIFICATE OF DEATH.

90

D 91888

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3123 Forster ay ST., 1 WARD)

2-FULL NAME Michael Wischer

(a) RESIDENCE NO 3123 Forster ay ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Wischer

6 DATE OF BIRTH (month, day, and year) Dec 30 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... N D
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Hehring
(Address) 3123 Forster ave

15 Filed ..... 192 ROBERT A. KRAUTER, Registrar
NOV 1 7 1924 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) James W Feulner, M. D.
(Coroner.)

Nov 10 1924 (Address) 907 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 12 1924
20 UNDERTAKER Lilly and Zile	ADDRESS 403 S. Wolfe St.

#91889
D 91889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91889

1-PLACE OF DEATH Union Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 901 St.; 7 WARD) REGISTERED No. C 186

2-FULL NAME William F Russell Jr

(Residence in Baltimore: No. 20 Evergreen ave St.; yrs., mos. ds.) Hamilton

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED~~ OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. (Month) 6 (Day), 1906 (Year)

7-AGE, 18 yrs. 0 mos. 3 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scholar at
(b) General nature of industry, business, or establishment in which employed (or employer): school.

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Wm F Russell, Sr.

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Mary T Donamon

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary T Russell

(Address) 20 Evergreen ave Hamilton

15- NOV 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 9 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
due to Collision with
Auto
Contusion of
Brain
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Thomson M. D.
(Coroner)

11/11, 1924 (Address) 3632 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. ...yrs. ...mos. ...ds. In the State. ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Harford Rd

DATE OF BURIAL, 11/12, 1924

20-UNDERTAKER Geo F Kuth.

ADDRESS 1735 Harford ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91890

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 S. Streeper St ST., 8 WARD)

2-FULL NAME Mrs. Anna Sroka

(a) RESIDENCE NO. 1013 S. Streeper ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Sroka

6 DATE OF BIRTH (month, day, and year) Dec 3 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Grzech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mr Frank Curich Son 1613 S Stremper St.

NOV 1 1924

ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1924, to Nov. 9, 1924, that I last saw h[illegible] alive on Nov. 9, 1924, and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Probably chronic Nephritis with Hypertension

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 2124 Ashland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Nov 12 1924

20 UNDERTAKER John McWeber — ADDRESS 1803 Bank St

Cor.—1-12-23—M&T—100 Bks.

D 9189 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9189

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2307 N. Calvert ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael McIntyre

(a) RESIDENCE NO. 2307 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 60 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Huey

6 DATE OF BIRTH (month, day, and year) April 29, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James McIntyre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Harry J. McIntyre
(Address) 2307 N. Calvert St.

15 Filed NOV 12 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) John Mosnier M. D.
(Coroner.)

Nov 11, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/12 1924

20 UNDERTAKER Henry W. Spears & Son

ADDRESS 805 N. Calvert

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AKO D

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91892

D 91892

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 72 WARD)

2-FULL NAME Harriet E. Powell

(a) RESIDENCE No. 304 Winters Ave ST., Catonsville Md WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1918

7 AGE: Years 6 | Months 3 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York City

PARENTS

10 NAME OF FATHER: Harry C Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country): U S A

12 MAIDEN NAME OF MOTHER: Willie Wms

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga

14 Informant: Harry C Powell
(Address): 304 Winters Ave

15 Filed NOV 1 2 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 — 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Fractured Skull

(duration) yrs. mos. 2 hrs

CONTRIBUTORY (Secondary)

Struck by Auto. driven by Allen E. Weaver — Catonsville Md

(duration) yrs. mos.

(Signed) Thos B. Horton, M. D.
(Coroner)

Nov 11 — 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: Nov 12 1924

20 UNDERTAKER: Samuel Hawkins — ADDRESS: Mt Belle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 91893

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 926 E. Eager St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Parrell

(a) Residence No. 926 E. Eager St, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced ~~Husband~~ (or) WIFE of the late James Parrell

6-DATE OF BIRTH (month, day and year) April 15, 1844

7-AGE. 80 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer). Wife

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS

10-NAME OF FATHER. James Conway

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland Co. Wexford

12-MAIDEN NAME OF MOTHER. Margaret Conley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland Co. Wexford

14-Informant. Joseph P. Murphy

(Address) 926 E. Eager St.

NOV 1 2 1924

ROBERT H. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1924 to Oct 10 1924 that I last saw h[illegible] alive on Oct 8 1924 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 1 mos. ds

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 5 yrs. mos. ds

18-Where was disease contracted if not at place of death? 926 E Eager St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McFeeley M. D.

(Address) 702 Chase St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Nov. 13 1924

20-UNDERTAKER. Elmer W. Conklin — ADDRESS 2242 E. Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 91894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1534 / 1001 / 57 / 100D 91894 3

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatius Kerp

(a) RESIDENCE NO. 1862 Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Kerp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospill Records
(Address)

15 Filed NOV 12 1924, 19.. ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-7, 1924, to 11-11, 1924

that I last saw him alive on 11-10, 1924

and that death occurred, on the date stated above, at 12:50 a m

The CAUSE OF DEATH* was as follows:

Gangrene (Arteriosclerotic) of Leg

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude C. Brown, M. D.

11-11, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov 13 1924

20 UNDERTAKER Clarence E. Wright — ADDRESS [illegible]

Cor.—1-12-23—M&T—100 Bks.

D 91895 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. On way from East St to Spy 9 Bay 1 or 2 ST., 15 WARD) REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carlo Marciano

(a) RESIDENCE No 33-02 Cottage ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/4/1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oil inspector
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER G. Marciano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francesca Marenberti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Information Given by Giovanfattie Marciano
(Address) 3302 Cottage

15 Filed NOV 12 1924 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injured while at work No. 13 —
Gas on the ground of abdomen
and Chest (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar (duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)
Nov 11, 192 4 (Address) 1179 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 7 months
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	11/12 192 4
20 UNDERTAKER George J Ruth	ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91896

CERTIFICATE OF DEATH.

100-001

D 91896

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N. Bond St ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie G. Davenport

(a) RESIDENCE No 306 N. Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct. 19/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Herbert Davenport

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mannie Jeffers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mannie Jeffers Davenport
(Address) 306 N. Bond St

15 Filed NOV 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Broncopneumonia (Primary)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Wall, M. D.
(Coroner.)

11/11/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury Cemetery — DATE OF BURIAL: nov 12 1924

20 UNDERTAKER: Edward Bryon — ADDRESS 1631 orleans st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+153 D 91897

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master Granville Haines Hibbard Jr.

(a) RESIDENCE NO. Brooklandville, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Granville H. Hibbard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Fannie L. Janney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lee. Va.

14 Informant: Granville H. Hibbard
(Address) Brooklandville Md

15 Filed NOV 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov 4, 19 24, to Nov 11, 19 24,

that I last saw him alive on Nov 11, 19 24,

and that death occurred, on the date stated above, at 9.57 Am.

The CAUSE OF DEATH* was as follows:

Septicemia

Staphylococcus aureus.

Original focus not known.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Osteomyelitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov 4, 1924

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) A.B. Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Nov 13 1924

20 UNDERTAKER: John O Mitchell ADDRESS: 1301 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91398

D 91398

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4803 Park Heights Av ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Shaw Mann

(a) RESIDENCE. No. 24 E. Virginia Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 9. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Ellen Watt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mary F. Mann

(Address) 124 E Virginia ave

NOV 12 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 16th 1923. to Nov 10th 1924.

that I last saw h alive on Nov 10th 1924.

and that death occurred, on the date stated above, at 12-12 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Rubert M. D.

. 19 (Address) 4854 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Nov 12 192

20 UNDERTAKER ADDRESS

John Oberndorf 1208 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Linck

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91899

D 91899

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Ensor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Linck

(a) Residence No. 921 Ensor St., 10 Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. 12 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry J. Linck

6-DATE OF BIRTH (month, day and year) Oct. - 28 - 1879

7-AGE. 45 yrs. — mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER John M. Rohlfing

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Salome Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md

14- (Informant) Mrs. Henry J. Linck

(Address) 921 Ensor St

NOV 1 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 19 24 to Nov 10 19 24

that I last saw h. 5f alive on Nov 10 19 24

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(Duration) 8 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Wheaton M. D

11/11/24 (Address) 4239 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery DATE OF BURIAL. Nov. 13 19 24

20-UNDERTAKER. Henry Hoerle Son ADDRESS 130 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Long 925 Harford Rd

Spec.—1-10-21—M&T—1500 Bks.

D 91900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91900

CERTIFICATE OF DEATH.

REGISTERED NO. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Troymore Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Halfpenny

(a) RESIDENCE NO. 4 Troymore Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel H Halfpenny

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Strobeck

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs C. Pearl Marshall
(Address) 4 Troymore Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1924, to Nov 9, 1924, that I last saw h[illegible] alive on Nov 9, 1924, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uterine Carcinoma

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Dr. M. D.

Nov 10 1924 (Address) 27 W Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Nov 12 1924

20 UNDERTAKER Wm. Cook — ADDRESS 502 E North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

ROBERT R. KRAUTH
Deputy Registrar

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-001

D 91901

CERTIFICATE OF DEATH.

1 59 D 91901

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 134 Rockrund Ave ST., 27 WARD)

2-FULL NAME William Harvey Crouse

(a) RESIDENCE NO. 134 Rockrund Ave ST., WARD

(Usual place of abode) (If non-resident give city or town und State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Samuel T Crouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Genevive Adona

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Samuel T Crouse

(Address) 134 Rockrund Ave

15 Filed ....., 19..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Nov 10, 1924

that I last saw him alive on Nov 10, 1924

and that death occurred, on the date stated above, at 10-10 P m.

The CAUSE OF DEATH* was as follows:

Congenital Hydrocephalus

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

Nov 11, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL Nov 12 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 91902 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91902

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Jo Hospital Registered No.

City of BALTIMORE: (No. Baltimore St., 27 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ella Louise Hartnagle

(a) Residence No. 5205 Ardmore Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

4-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
F.	W	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of August

6-DATE OF BIRTH (month, day and year) Feb 5 1857

7-AGE	If LESS than 1 day,
68 yrs. 9 mos. 7 ds.	hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) R. I.

PARENTS:
10-NAME OF FATHER, Don't Know
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12-MAIDEN NAME OF MOTHER, Don't Know
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14- (Informant) Geo. P. Hartnagle
(Address) 5205 Ardmore Ave

15- FILED NOV 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 11-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 19 24 to Nov 11th 19 24, that I last saw h.e.a. alive on Nov 11th 19 24, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary edema
(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 8th /24
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) G. B. Sybert, M. D.
, 19 (Address) St Jo Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Parkwood Ser	14

20-UNDERTAKER	ADDRESS
Wm Cook	532 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 91903

CERTIFICATE OF DEATH.

D 91903

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Saunders

(a) RESIDENCE No. 1426 W. Mosher St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 0/0
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Benj Saunders

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Febe Heath

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John M. Dunn
(Address) 703 Saratoga St.

15 Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said enquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd degree burns of body, accidental (duration) ..... yrs. ..... mos 5 hrs. ..... ds.

CONTRIBUTORY (Secondary) Cooking carpet fire from coal stove (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 10. 1924 (Address) 202 Courtenay Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Inatitutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester ste. Kent Isld. Md — DATE OF BURIAL Nov 13 1924

20 UNDERTAKER J. L. Brown & Son — ADDRESS 118 N. Mond

Sta cambridge Kent Island

Burial Permit Gen'l A -

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 91904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4th D 91904

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 W. Fayette ST., W WARD)

2-FULL NAME Walter S. Turner

(a) RESIDENCE NO 2314 W. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Turner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 48
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Walter B. Turner

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. Elizabeth Turner
(Address) 2314 W. Fayette St.

15 Filed NOV 12 1924 Burial Permit Clerk,
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Cancer of Liver
Unknown
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton, M. D.
(Coroner.)
Nov 11th 1924 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Inatitutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Nov. 12 1924

20 UNDERTAKER George L. Schwab ADDRESS 2101 Buck. Ave.

NOTE—MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91905

CERTIFICATE OF DEATH.

D 91905
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2709 Fredenfs ST., 20 WARD)

2-FULL NAME William H. Lamb

(a) RESIDENCE NO. 2709 Fredenfs ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15-1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Umbrella
(b) General nature of industry, business, or establishment in which employed (or employer) Lifer
(c) Name of employer Balto. Md 846

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Lamb
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md
12 MAIDEN NAME OF MOTHER Margaret Stewart
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles Smith
(Address) 2709 Fredenfs ave

15 NOV 12 1924
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1924 to Nov 10 1924.
That I last saw him alive on Nov 9 1924.
and that death occurred, on the date stated above, at 2 9 m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Intracerebralis

(duration) Unknown mos. da.

CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert A. Pietsch M. D.
11/10/1924 (Address) 2152 Wilkins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov. 12 1924

20 UNDERTAKER George L. Schmat ADDRESS 1107 Park ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

Spec—12-23-21—E.B.R.S.—400 Bks.

91906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 91906

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1903 Ashland ave St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Anna Pasek.

(a) Residence No. 1903 Ashland ave St., 7th Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6-DATE OF BIRTH (month, day and year) 1863

7-AGE. 61 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Work.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Bohemain Europe.

PARENTS

10-NAME OF FATHER. Joseph. Lusicka

11-BIRTHPLACE OF FATHER (city or town). Not Knowing (State or Country). Bohemian Europe

12-MAIDEN NAME OF MOTHER. Not Knowing

13-BIRTHPLACE OF MOTHER (city or town). Not knowing (State or Country). Bohemian Europe

14-

(Informant). Anton Pasek.

(Address)..... 802 n Rose st.

15-

NOV 12 1924 FOREST K. [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 10 1924

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1924 to Nov 10 1924

that I last saw h[illegible] alive on Novemb 10 1924

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

(Cancer & Complication of Carcinoid Intestinal Nephritis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas F. Dommy M. D.

, 19 (Address) 1025 N [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Hill	Nov 14, 1924

20-UNDERTAKER. August D Pasek

ADDRESS 721 North Gilmor Street

N. B.—WHITE PAPER, WRITING SHOULD be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important—See instructions on back of certificates.

Stone—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91907

CERTIFICATE OF DEATH.

74-201

D 91907

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Home for Incurables St., 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie A. Churchill

(a) Residence No. Guilford Ave & 20 St., Ward

(Usual place of abode) North Carolina

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced (Write the word.): single

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: single

6-DATE OF BIRTH (month, day and year): Mch 1839

7-AGE: 85 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): N.C.

PARENTS

10-NAME OF FATHER: Chapell Churchill

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Eliz. Allen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): N.C.

14- (Informant): Paul C. Hutton

(Address): Denver Col

15- Filed, 1924. ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 12-24

17- I HEREBY CERTIFY, That I attended deceased from March, 1922 to Nov 12, 1924, that I last saw her alive on Nov 12, 1924, and that death occurred, on the date stated above, at 5a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis —

Paralysis —

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W. W. Keen M. D.

Nov 12, 1924 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Goldsborough N.C.	Nov 14 1924
20-UNDERTAKER	ADDRESS
John O Mitchell	1201 N. Fayette

NOV 7 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91908

CERTIFICATE OF DEATH.

197 D 91908

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Johnson (Taylor)

(a) RESIDENCE No 904 Abraham St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johnson

6 DATE OF BIRTH (month, day, and year) March 14/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7 ~~8~~	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER Sandy Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md

14 Informant Alfred Taylor (Bro)
(Address) 810 Sterling St

15 NOV 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol Shot wound of abdomen
(Homicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Hamilton, M. D.
(Coroner.)
11/12/24 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woburn Home	11/13 1924
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Biddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 91909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91909 36-005

D 91909

CERTIFICATE OF DEATH ~~STILL BIRTH~~ No.

1-PLACE OF DEATH

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST., 2 WARD)

2-FULL NAME Maria Finnerty

(a) RESIDENCE No. 1636 Thames St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 1 1924, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Nov 1, 1924, that I last saw h alive on Nov 1, 1924, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis

(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) Emphysema - streptococcus infection (duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ..... 19..

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas Harold Davis, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	NOV 11 1924
20 UNDERTAKER Commissioner of Health.	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91910 (22-253)

D 91910

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Odum

(a) RESIDENCE NO. 540 E. McMechen ST., .. WARD ..

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): +

(c) Name of employer: +

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 12 1924 ROBERT R. KRAUTER, Registrar

1935 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31 1924

17 I HEREBY CERTIFY, That I attended deceased from October 25, 1924, to October 31, 1924, that I last saw him alive on October 31, 1924, and that death occurred, on the date stated above, at 12 2 m.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic endarteritis (Brain).

(Hemiplegia.

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Syphilitic aortitis

(duration) ... yrs. 5 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann.

(Signed) Trevor Owen, M. D.

Nov 10th, 1924 (Address) Johns Hopkins Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 11 1924
20 UNDERTAKER	ADDRESS
Per Wm. E. McGrath.	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91911

CERTIFICATE OF DEATH.

4 4

D 91911

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Grey

(a) Residence No. 657 Patapsco St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1877

7-AGE, 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Donnell

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- NOV 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-10-24

17- I HEREBY CERTIFY, That I attended deceased from 4-19, 1924, to 11-10, 1924

that I last saw him alive on 11-10, 1924

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) yrs. 8 mos. (Hist.)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Thomas, M. D.

11-10, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Westlawn DATE OF BURIAL, Nov. 12 1924

20-UNDERTAKER, Leonard Wall ADDRESS 673 Saratoga

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-24—M&T—100 Blks.

D 91912

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 91912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Ensor St ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Matthews

(a) RESIDENCE NO 71 Ensor St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Oct 12/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	0	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Norman Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Strasburg Pa.

12 MAIDEN NAME OF MOTHER Homezel Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Homezel Matthews
(Address) 712 Ensor St

Filed NOV 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Ricketts),

(duration) ... yrs. ... mos. ... ds.

(Signed) J. Sollmann, M. D.
(Coroner.)

11/12/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	NOV 12 1924
20 UNDERTAKER	ADDRESS
Joseph T. H. Rochester	1413 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91913
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 91913
REGISTERED No. C

CITY OF BALTIMORE (No. 1521 Presstman ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Brown

(Residence in Baltimore: No. 1521 Presstman St St.: yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Oct 20, 1924
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country) Balto md.

PARENTS.

10-NAME OF FATHER, Theodore Brown

11-BIRTHPLACE OF FATHER (State or Country), Alexandria Va.

12-MAIDEN NAME OF MOTHER Pearl Harcombe

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Harcombe

(Address) 1521 Presstman St.

15- NOV 12 1924

By ROBERT R. KRAUTER, (Registrar.)
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Gastro-enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Sweeney (Coroner.) M. D.

Nov. 11, 1924 (Address) 1802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Cemetery	Nov 13, 1924
20-UNDERTAKER Mrs Jas. H. Dennis	ADDRESS 1302 Presstman St

Spec– 12-23-21–E.B.R.S.—400 Bks.

D 91914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91914

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 N. Mount St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Teppara

(a) Residence No. 806 N. Mount St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: C.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1887

7-AGE: 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va

PARENTS.

10-NAME OF FATHER: Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.

12-MAIDEN NAME OF MOTHER: Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown.

11- (Informant): Ollie Coleman

(Address): 806 N. Mount st.

15- Robert F. Carrick, Registrar.

Filed ..... 19?

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 9-24

17- I HEREBY CERTIFY, That I attended deceased from October 7 – 1924 to Nov. 9 – 1924

That I last saw her alive on Nov 9 – 1924

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Carcinoma of Uterus (Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (Duration) yrs. 8 mos. 25 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. S. W. Kennard M. D

11-10-1924 (Address) 708 Ensor st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hawkins Sta. Fairmount Cem. DATE OF BURIAL: Nov. 13. 1924

20-UNDERTAKER: Mrs R. G. Elliott ADDRESS: 1725 Ashland

OV 1 21924

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91915

D 91915

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 9 WARD)

2-FULL NAME Hattie Link

(a) RESIDENCE No. 3020 Montebello Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Stony Creek
(State or country) A.A. Co. Md

PARENTS

10 NAME OF FATHER Charles Link

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Antonia Grigolat

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mother
(Address) Robert F. Arrison,

15 Filed ..... 19 ..... Registrar
[illegible] Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924, to Nov 12, 1924.

that I last saw h[illegible] alive on Nov 12, 1924,

and that death occurred, on the date stated above, at 4.03 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubation Date of 11/10/24

Was there an autopsy? none

What test confirmed diagnosis? Bac. Culture

(Signed) Myron G Tull, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — DATE OF BURIAL: Nov 12 1924

20 UNDERTAKER: Ed Roy Stiffler — ADDRESS: 125 North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91916

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Boyd st. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Dulski

(a) RESIDENCE No 939 Boyd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Stevedore

9 BIRTHPLACE (city or town) Georgia
(State or country)

PARENTS

10 NAME OF FATHER Geo. Smith

11 BIRTHPLACE OF FATHER (city or town) Georgia
(State or country)

12 MAIDEN NAME OF MOTHER Frances Smith

13 BIRTHPLACE OF MOTHER (city or town) Georgia
(State or country)

14 Informant Frances Smith
(Address) 939 Boyd St.

15 Filed ....., 192 .....

Robert P. Harrison,
Registrar
Burial Permit Clerk.

VT 2 1924

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. H. Yeatman, M. D.
(Coroner.)

11-11, 192 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Albion Cemtery — DATE OF BURIAL Nov 12, 1924

20 UNDERTAKER Walter B. Spriggs — ADDRESS 114 N. Schroeder St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 91917.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91917.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 537 Hollins St. 8 WARD)

REGISTERED NO. 112.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Barker

(a) RESIDENCE. No. ..... ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Annie E Gyber
(Address) 537 Hollins St

15 Filed NOV 12 1924

Robert P. Harrison Registrar

Deputy Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12- 1924

17 I HEREBY CERTIFY, That I attended deceased from April 12 1924, to Nov 17, 1924, that I last saw her alive on Nov 10, 1924, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea and enteritis

(duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John Lee Baldwin, M. D.

, 19 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: Nov 12 1924

20 UNDERTAKER (Commissioner of Health.) — ADDRESS

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 1 2 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91918

1-PLACE OF DEATH

City of BALTIMORE: (No. 228 E. Church St., 27 Ward)

Registered No. 89

2-FULL NAME James Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 228 E. Church St.,

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. Ward

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Miller

6-DATE OF BIRTH (month, day and year) 1-1870

7-AGE. 54 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 440

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Joseph Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margt Hughes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Mrs. Mary Miller

(Address) 228 E. Church St.

15- Filed NOV 12 1924, 192

Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922 to Nov 10, 1924

that I last saw h[illegible]live on Nov 10, 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. F. Campbell M. D.

Nov 12, 1924 (Address) 1646 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem.

DATE OF BURIAL. Nov 13, 1924

20-UNDERTAKER. F. A. Frames & Son

ADDRESS 708 Hanover St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 12 1924

Spec– 12-23-21– E.B.R.S.–400 Bks.

D 91919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 E. Heath St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Vandouarn

(a) Residence No. 19 E. Heath St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 26-1923

7-AGE. 1 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto

PARENTS.

10-NAME OF FATHER. George A Vendouern

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Jennie V. Stanley

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Balto

14- (Informant) Geo A. Vendouern

(Address). 19 E Heath St

15- Filed NOV 12 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 12-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 8, 19 24, to Nov 12 19 24

that I last saw h... alive on Nov 12 19 24

and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria - Laryngeal

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) M L Beiser M. D

11/12, 1924 (Address) 1319 Lights St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill Cem. A.A. Co.	11/13/24. 19....
20-UNDERTAKER. Fred A. Kramer & Son.	ADDRESS 703 Hanover St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91920

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Franklin St., Row 46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Murray

(a) Residence No. 920 Franklin St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Wht

5-Single, Married, Widowed, or Divorced. (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 1867

7-AGE. 57 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Maine

PARENTS.

10-NAME OF FATHER. James A Tyson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Maine

12-MAIDEN NAME OF MOTHER. Marie Farnham

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Maine

14- (Informant) J E Tyson

(Address) 920 Franklin St

15- Filed Nov 21 1924 Robert P. Haffner Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 10 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to Nov 10, 1924, that I last saw h[illegible] alive on Nov 10, 1924, and that death occurred, on the date stated above, at 10 10 m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Hoover M. D.

Nov 11, 1924 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Nov 12, 1924

20-UNDERTAKER. F. A. Furnes & Son ADDRESS 703 Hanover St

NOV 21 1924

IMPORTANT—REGISTRAR'S NOTICE: EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9192E

D 9192I

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1011 W. Gay (St.:) 8 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Smith

(a) RESIDENCE. No. 1011 W. Gay St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Wm Smith

6 DATE OF BIRTH (month, day, and year): Nov 2 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Allen J. Krentler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margt Dillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Allen J. Krentler

(Address) 1311 W. Gay

15 Filed NOV 12 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Nov 11, 1924, that I last saw h alive on Nov 10 1924, and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pelvis

Bladder

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of July 23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Barnes M. D.

(Address) 1270 Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dale Redeemer	11-14 1924

20 UNDERTAKER: Stephen Beckenmeyer ADDRESS 1370 S Charles

NOV 12 1924

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91922

CERTIFICATE OF DEATH.

90 D 91922

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 815 S. Linwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Murphy

(a) Residence No. 815 S. Linwood Ave St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Murphy

6-DATE OF BIRTH (month, day and year) Dec 5- 1856

7-AGE. 67 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland.

PARENTS

10-NAME OF FATHER. Michael Howard

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Mary Costigan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland.

14- (Informant) William Murphy

(Address) 817 S. Linwood Ave

15- Filed Robert P. Harrison, Registrar.

V 1 21924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1924 to Nov 10 1924 that I last saw h[illegible] alive on Nov 10 1924 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

1 Hemiplegia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death? At residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. L. Burke M. D

1924 (Address) 3042 Hudson St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL. Nov. 13 1924

20-UNDERTAKER. Lilly & Julen ADDRESS 403 S. Wolfe St.

WHITE PENCIL. WRITING UNFADING INK should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91923 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 91923

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3700 Mt. Pleasant Ave. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John L. Kraus.

(a) Residence No. 3700 Mt. Pleasant Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Kraus.

6-DATE OF BIRTH (month, day and year) Nov 3 – 1875

7-AGE, 49 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Tailor Shop

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Conrad Kraus

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Frances Schaefer

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant)..... Mary L. Kraus
(Address)..... 3700 Mt. Pleasant Ave.

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

NOV 12 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 11-1924

17- I HEREBY CERTIFY, That I attended deceased from July 8, 1924 to Nov 11, 1924 that I last saw him alive on Nov 11, 1924 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(Duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (Duration) X yrs. 6 mos. X ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Jas. L. Kraus M. D.

Nov 12, 1924 (Address) 248 S. Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart	Nov. 14, 1924
20-UNDERTAKER. Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

Instructions on back of certificates. In plain terms, so that it may be properly classified. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

D 91924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91924

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Fairy Gregg

(a) RESIDENCE NO. 416 Maine St Roncevert WARD W Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer ..... —

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER George W. Gregg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Katie Everett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant ..... Records

(Address) JOHNS HOPKINS HOSPITAL

DEC 1 2 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924, to Nov 11, 1924, that I last saw h[illegible] alive on Nov 11, 1924, and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Infection of Congenital Hypertrophy of 2d Leg

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Roncevert W. Va

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roncevert W Va	11/12 1924
20 UNDERTAKER	ADDRESS
Joseph Ahern's	22 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Dr Leonarddis)

(D 91925) HEALTH DEPARTMENT—CITY OF BALTIMORE D 91925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. DeLeonarddis

(a) RESIDENCE NO. 278 N. Exeter ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. — mos. 12 ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Joseph DeL. Died 1896

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country) U. S.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

NOV 12 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924, to Nov 11, 1924
that I last saw her alive on Nov 11, 1924,
and that death occurred, on the date stated above, at 12 M a.m.
The CAUSE OF DEATH* was as follows: Cardiac failure.

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Rheumatic endocarditis.

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) W. Almazan, M. D.
11/11, 1924 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 11/13 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E. Balt St.

NOV 12 1924

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D A K O

Spec.—1-10-21—M&T—150G Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91926

CERTIFICATE OF DEATH.

D 91926

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 N.Patterson Park Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Burns

(a) RESIDENCE NO. 1412 N.Patterson Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, ~~or divorced~~
~~HUSBAND OF~~
(or) WIFE of John T.Burns

6 DATE OF BIRTH (month, day, and year) ? • ?- 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): house work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co.Md

PARENTS

10 NAME OF FATHER: George H.Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Maryland

12 MAIDEN NAME OF MOTHER: Susan Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co. Maryland

14 Informant: Mrs.Susan Reynolds
(Address): 1412 N.Patterson Park Ave

15 Filed NOV 12 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov.11.1924

17 I HEREBY CERTIFY, That I attended deceased from January 1. 1924, to Nov. 10. 1924.

that I last saw her alive on Nov. 10. 1924,

and that death occurred, on the date stated above, at 3:35 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. H. Hartman, M. D.

Nov 12. 1924 (Address) 2211 Maryfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 11-14-24

20 UNDERTAKER: H. E. Myers & Co. — ADDRESS: 424 N.Broadway

NOV 12 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91927

CERTIFICATE OF DEATH.

31 D 91927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 17 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Wallace

(a) RESIDENCE No. 915 W. Elm st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wallace

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Henry Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed NOV 12 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1924, to Nov. 10, 1924, that I last saw h.. alive on Nov. 10, 1924, and that death occurred, on the date stated above, at 10.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum, autopsy

(Signed) Richard Short, M. D.

11-11-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-14-24
20 UNDERTAKER	ADDRESS 916
Lynch Eastern	Co ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Time of burial postponed to Friday Nov. 14/24 3 2 p.m. J. Frederick Hemple

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91928

CERTIFICATE OF DEATH.

D 91928 REGISTERED NO. 7 Block

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Parr

(a) RESIDENCE NO. 801 Wordyer ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records (Address)

15 Robert P. Harrison, Registrar

NOV 12 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 8 1924

17 I HEREBY CERTIFY, That I attended deceased from 7 - 7, 1924, to 11 - 8, 1924

that I last saw him alive on 11 - 8, 1924

and that death occurred, on the date stated above, at 11 2 8 m.

The CAUSE OF DEATH* was as follows:

Syphilis. Syphilitic Aortitis; Aortic insufficiency; Myocardial insufficiency

(duration) 1½ yrs. (History) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude G. Draper, M. D.

11-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-14 1924
20 UNDERTAKER	ADDRESS
David Carter	916 Pa ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91929

CERTIFICATE OF DEATH.

90 D 91929

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Bonheim

(a) RESIDENCE. No. 2321 Eutaw Pl. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Rachel Bonheim

6 DATE OF BIRTH (month, day, and year): Nov 7-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Ye~~ 74 ~~Mo~~		0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bailiff

(b) General nature of industry, business, or establishment in which employed (or employer): Clerical

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs Benj. Bonheim 1929 E. Monument St

15 Filed NOV 12 1924 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-12- 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-12- 1924 to 11-12 1924.

that I last saw him alive on 11-12- 1924.

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

130 Rm.

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Pedro Ribeiro M. D.

11/12/ 1924 (Address) 914 Ridgely

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Shalom Cem.	11/14 1924

20 UNDERTAKER: Levi Sondheim ADDRESS: 1150 W. Mt. Royal Ave

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANSWERS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Covey)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91930

D 91930

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John s Hopkins Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Covey

(a) RESIDENCE No. 5. Midvale Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no ne

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) Servant
(c) Name of employer Mrs, Weston

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Covey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital
(Address)

Filed NOV 12 1924 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
1st, 2nd & 3rd degree burns over lower abd., back, buttocks, thighs & upper legs.
Dress caught fire while passing gas range. (accidental)
(Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. O'Brien, M. D.
(Coroner.)

11/12/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Md	11/12 1924
20 UNDERTAKER Joseph Ahern	ADDRESS 221 B...

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9193I

CERTIFICATE OF DEATH.

100-801

D 9193I

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 Archer ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alvin Richardson

(a) RESIDENCE NO 619 Archer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31st 24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	2	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Alvin McCoy

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Richardson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Information Evelyn Richardson
(Address) 619 Archer St.

15 NOV 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by a Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D.
(Coroner.)

Nov 12 1924 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL Nov 13 1924

20 UNDERTAKER W. L. Brown & Son — ADDRESS Wilkins Ave

NOTE—NAME OF DECEASED, NATIVITY, OCCUPATION AND RESIDENCE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91932

CERTIFICATE OF DEATH.

90 D 91932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Peach alley ST., 23 WARD)

2-FULL NAME Harry Calhun Cooper

(a) RESIDENCE NO. 914 Peach alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Westilia Cooper

6 DATE OF BIRTH (month, day, and year) 4-4-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hollwood's Restaurant 1021

9 BIRTHPLACE (city or town) Balto city (State or country)

PARENTS

10 NAME OF FATHER Charles Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Maime Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Westilia Cooper (Address) 914 Peach alley

15 NOV 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11-1924

17 I HEREBY CERTIFY, That I attended deceased from 11/8, 1924, to 11-11-, 1924, that I last saw him alive on 11-8, 1924, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Jackson, M. D.

11/12 1924 (Address) 818 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov 14 1924

20 UNDERTAKER: John H. Fowden — ADDRESS: 1027 Pennsylvania

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-001

10 D 91933

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 114 S. Schroder ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Miller

(a) RESIDENCE No 114 S Schroder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (~~HUSBAND~~ of) (or) WIFE of Geo C. Miller

6 DATE OF BIRTH (month, day, and year) JAN 19 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Jos Lechlider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER M E Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant Robert Brooks

(Address) Calhoun & Hollins Sts

15 NOV 13 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1924, to Nov 11, 1924, that I last saw her alive on Nov 10th, 1924, and that death occurred, on the date stated above, at 10. A.M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

D Pneumonia

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of:

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Bernard Levy, M. D.

Nov 12 1924 (Address) 910 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 14 1924
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91934

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 91934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hosp. 27 ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Yingling

(a) Residence No. North Ave. Mt Washington ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes M Yingling

6-DATE OF BIRTH (month, day and year) Mar 12-1857

7-AGE 37 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheet metal Worker

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Jos Yingling

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Amanda Corbin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Agnes M Yingling

(Address) 109 North Mt Wash

NOV 13 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 28, 1924 to Nov. 11, 1924

that I last saw him alive on Sept 11, 1924

and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Streptococcus

(Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Gastric ulcer

(Duration) 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of Sept 29/24

Was there an autopsy? No

What test confirmed diagnosis? Phys & Clin Test

(Signed) Leo. P. Hyland M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Nov 14, 1924

20-UNDERTAKER P B Maus Lic 3339

ADDRESS Fulton Ave

N. B.—WRITE PLAINLY, with UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91935

CERTIFICATE OF DEATH.

1925 D 91935

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Herbert or Rachubinski

(a) RESIDENCE NO 623 S Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 23 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gate Tender
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J. Dunn

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Mich. Rachubinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Susan Borazeska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Rachubinski
(Address) 623 S Rose

15 Filed NOV 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptd. Pericardium and other injuries 2 days
Accidental (duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptd Pericardium 1 day (duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Nov 12, 1924 (Address) 1659 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 1 yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Holy Rosary Cem.	Nov 13 1924
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91936

CERTIFICATE OF DEATH.

90 D 91936

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 Frisby St ST., 9 WARD)

2-FULL NAME Joseph Beckhardt

(a) RESIDENCE NO 2630 Frisby St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Street Huckster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

0461

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Abraham Beckhardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Julia C. Dietrick

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14

Informant Mrs Helen Brooks
(Address) 1459 Columbia Ave

15 Filed NOV 13 1924 ROBERT R. ... Register
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to h&D death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(Valvular probably)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) J S H Pollitt, M. D.
(Coroner.)

11/12/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: 11/13 1924

20 UNDERTAKER — ADDRESS: E Baltimore St

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91937

D 91937.

CERTIFICATE OF DEATH.

Registered No. 49

1-PLACE OF DEATH

City of BALTIMORE: (No. 2787 Tivoly ave St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Horace Winter Michael

(a) Residence No. 2787 Tivoly ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth E. Michael

6-DATE OF BIRTH (month, day and year) Nov 7th 1875

7-AGE, 49 yrs. 0 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Hanover Pa

PARENTS.

10-NAME OF FATHER Alphus W. Michael

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hanover Pa

12-MAIDEN NAME OF MOTHER Emma Winebrenner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Hanover Pa

14- (Informant) Mrs. Elizabeth E. Michael

(Address) 2787 Tivoly ave

NOV 13 1924

15- ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 11th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924, to Nov 11, 1924, that I last saw h. alive on Nov 11, 1924, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James D. McCurdy M. D.

, 19 (Address) 416 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hanover Pa — DATE OF BURIAL. 11/14/24

20-UNDERTAKER. Geo. Weber & Son — ADDRESS. 2503 Edmondson ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91938

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 932 E. Eager St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Stespelein

(a) Residence No. 932 E Eager St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Julius Stespelein

6-DATE OF BIRTH (month, day and year) June 22 1857

7-AGE. 67 yrs. 4 mos. 18 ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles A. Diely.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary A. Etzel.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant Mr. Julius Stespelein

(Address) 932 E. Eager St.

NOV 1 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924 to Nov 12 1924 that I last saw h. alive on Nov 9th 1924 and that death occurred, on the date stated above, at 6 A. M. The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Cancer Day Deformity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dry Gan

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Stone M. D.

Nov 12, 1924 (Address) 1817 E Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	Nov 15 1924
20-UNDERTAKER,	ADDRESS
Henry Woeckener	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

D 91939

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1817 Emma ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Sheselsky

(a) Residence No. 1817 Emma ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Sheselsky

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Jacob Sheselsky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Sohe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto

15- NOV 13 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-12-24

17- I HEREBY CERTIFY, That I attended deceased from July 20 19 24 to Nov 12 19 24

that I last saw h. alive on Nov 12 19 24

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of urachus

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General metastasis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D.

11/12, 19 24 (Address) 733 Asquith st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holden Herring Rem	11-13, 19 24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—This certificate is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91940

CERTIFICATE OF DEATH.

D 91940
1-PLACE OF DEATH

REGISTERED NO. 90 D 91940

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (NO. 1237 N. Washington St ST., 8 WARD)

2-FULL NAME Rachel Minster

(a) RESIDENCE NO 1237 N. Washington St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white ~~col~~	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Morris Minster

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hirsh Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinda Friedman (relative)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Anna Brofman
(Address) 1237 N. Washington St

15 Filed. NOV 1 1924 Robert M. Minster
Burial Permit Clerk Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency-probably Valvular)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Hollis, M. D.
(Coroner.)

11/12/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Milrew Wash. Road — DATE OF BURIAL 11-13 192 4

20 UNDERTAKER Jack Levis, 1432 E Balto — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91941

CERTIFICATE OF DEATH.

D 91941

1-PLACE OF DEATH

City of BALTIMORE (No. 1530 Appleton St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Liberstein

(a) Residence No. 1530 St. Appleton Street, Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Liberstein

6-DATE OF BIRTH (month, day and year)

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Liberstein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unkan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1409 E Balt St

15-

Filed NOV 13 1924 19.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 12-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 19 24, to Nov 12, 19 24, that I last saw h. alive on Nov. 12, 19 24 and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lungs

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(Duration) yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and microscopical B. Kadyan M. D.

(Signed)

19 (Address) 2306 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Sinai Mt Carmel	11-13 19 24
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1409 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 91942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 91942

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 808 W Franklin ST., 17 WARD)

2-FULL NAME James Edward Hall

(a) RESIDENCE NO. 808 W Franklin ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sep 30, 1923

7 AGE — Years: 1 — Months: 1 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Mary Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charlestown W Va

14 Informant: Charles Hall
(Address): 808 W Franklin St

15 NOV 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924 to Nov 11, 1924 that I last saw him alive on Nov 11, 1924 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Nov 13 1924

20 UNDERTAKER: John H Owens — ADDRESS: 538 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91943

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2004 N. Payson ST., 15 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casandra Jean

(a) RESIDENCE No. 2004 N. Payson ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Jean

6 DATE OF BIRTH (month, day, and year) Oct. 17-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jacob A. Jean 2004 N. Payson St.

15 Filed NOV 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 25" , 1924 , to Nov 12 , 1924 ,

that I last saw her alive on Nov 12 , 1924

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Duvall, M. D.

11/13, 1924 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Nov. 15 1924

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Fairfield

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91944

CERTIFICATE OF DEATH.

61-001

D 91944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3513 Railroad Ave ST., 13 WARD)

2-FULL NAME James T. Smith Jr.

(a) RESIDENCE NO. 3513 Railroad Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 12-1924

7 AGE	Years	Months	Days	If LESS than 1 day, Hrs or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James T. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Myrtle Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant James T. Smith

(Address) 3513 Railroad Ave.

NOV 13 1924

Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-12, 1924, to 11-12, 1924.

that I last saw h[illegible] alive on 11-12, 1924.

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Premature gestation

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Endocarditis Chronic Valvular Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Expelled ovum

(Signed) C. F. Campbell, M. D.

11-13 1924 (Address) 820 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Nov. 13 1924
20 UNDERTAKER	ADDRESS
Horace H. Burgee	323 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 Chelsea Terrace St. 15 WARD)

2-FULL NAME Baby Bennett

(a) RESIDENCE NO. 2706 Chelsea Terrace St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

16 2

D 91945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced. (write the word): Single

5a If ~~married, widowed,~~ or divorced HUSBAND of (or) ~~WIFE of~~: Child

6 DATE OF BIRTH (month, day, and year) Nov 12th 1924

7 AGE: Years 8 hrs. | Months | Days | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Elton J. Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Flossie Bedell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Elton J Bennett

(Address) 2706 Chelsea Terrace

15 Filed NOV 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 12th, 1924, to Nov 13th, 1924,

that I last saw h living alive on Nov 13th, 1924

and that death occurred, on the date stated above, at 4 a-m.

The CAUSE OF DEATH* was as follows:

Strangulation - Cord around neck when born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions. 2 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual signs

(Signed) D. A. Waldrary, M. D.

11-13-1924 (Address) 210 East Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 18 1924

20 UNDERTAKER: Henry W. Jenkins & Sons Co — ADDRESS: Eutaw & Baltimore Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Heinz Rosenthal

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91946

CERTIFICATE OF DEATH.

4th D 91946

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643 E Fayette ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanze Rosenthal

(a) RESIDENCE NO 1643 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 3 yrs. 6 mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Russia

PARENTS

10 NAME OF FATHER Tavan Chirona

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lena Sulber

(Address) 2924 Park Heights ave

15 Filed NOV 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17

I HEREBY CERTIFY, That I attended deceased from June 15 1924 to Nov 12 1924

that I last saw her alive on Nov 12 1924

and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

+ Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 wks ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W J Bayliss, M. D.

11/13, 1924 (Address) 210 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rockdale Cemetery

DATE OF BURIAL Nov 13 1924

20 UNDERTAKER J Jerusalem Bro

ADDRESS 1227 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91947 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 91947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 N. Bethel St ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Cassell

(a) RESIDENCE NO 621 N. Bethel St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Cassell

6 DATE OF BIRTH (month, day, and year) unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer self

823

9 BIRTHPLACE (city or town) .....
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Cassell Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Anna Cassell
(Address) 621 N. Bethel St

15 NOV 13 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Culler, M. D.
(Coroner.)

11/12/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Nov 13 1924

20 UNDERTAKER Mrs P. G. Elliott ADDRESS 1725 Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91948

CERTIFICATE OF DEATH.

D 91948

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

2-FULL NAME Baby Elizabeth Story Latimer.

(a) RESIDENCE NO. 3314 Jwyns Falls ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby.

6 DATE OF BIRTH (month, day, and year) 5/2/24

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nursery.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Alfred Story Latimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Elizabeth Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Father

(Address) 3314 Jwyns Falls. Md.

15 Filed NOV 3 1924 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10/24 19

17

I HEREBY CERTIFY, That I attended deceased from 11/10/24, 19, to 11/10/24, 19, that I last saw h-r alive on 11/10/24, 19, and that death occurred, on the date stated above, at 5:50 P m.

The CAUSE OF DEATH* was as follows:

Intersusception

11/8/24 — 11/10/24 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intersusception. Surgical shock. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes Date of 11/10/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical evidence

(Signed) E. L. Young, M. D.

, 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Woodlawn Cem. Nov. 13 1924

20 UNDERTAKER — ADDRESS

Wm. C. Black 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91949

CERTIFICATE OF DEATH.

D 91949

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sophronia Johnson.

(a) RESIDENCE NO. Whiteford, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred non-resident 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of William H Johnson

6 DATE OF BIRTH (month, day, and year) Apr. 15 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County, Md.

PARENTS

10 NAME OF FATHER John Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County, Md.

12 MAIDEN NAME OF MOTHER Sarah Blaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County, Md.

14 Informant (Address) Mrs Sophronia Johnson Harford County, Md.

15 NOV 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13 1924

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1924, to 11/13, 1924,

that I last saw her alive on 11/13, 1924,

and that death occurred, on the date stated above, at 3 a0 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) yrs. 5 mos 15 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

3 minutes.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Slate Ridge Leem Delta Pa	Nov 15 1924
20 UNDERTAKER E G Kurtz & Son	ADDRESS [illegible]

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91950 ✓

D 91950
1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St. 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Norfolk

(a) Residence No. Bay View Asylum St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). England

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

NOV 13 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

1939

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-10-24

17- I HEREBY CERTIFY, That I attended deceased from 7-18, 1921, to 11-10, 1924, that I last saw him alive on 11-10, 1924, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis (Degenerative); Myocardial Insufficiency

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude S. Brace, M. D.

11-10, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL, ... 19....

20-UNDERTAKER. [illegible]

ADDRESS [illegible] Wm. E. WOODALL

NOV 13 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

34

Spec.—1-10-21—M&T—1500 Blks.

D 91952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 91952

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 714 Forest St., 10 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Costello

(a) RESIDENCE NO. 714 Forest St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of John E. Costello

6 DATE OF BIRTH (month, day, and year) Dec 4 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	48	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Hannan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary T. Costello (Address) 714 Forest St

Filed NOV 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924, to Nov 12, 1924, that I last saw h[illegible] alive on Nov 11, 1924, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

~~Chr Cystitis~~

Chr Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analysis

(Signed) L McCurdy M. D.

Nov 13, 1924 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/15/1924

20 UNDERTAKER E. J. Fanning & Son - 1938 E Lafayette Ave

ADDRESS

Spec- 12-23-21—E.B.R.S.—400 Blks.

Dicke

D 91952 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 57 D 91952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary — Registered No.....

City of BALTIMORE: (No..... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles M. Dicke Sr

(a) Residence No. 1825 E 32nd St — St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Regina Dicke

6-DATE OF BIRTH (month, day and year) June 18th 1857

7-AGE. 67 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpet Layer
(b) General nature of industry, business, or establishment in which employed (or employer) 186
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.
10-NAME OF FATHER, George Dicke
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Johanna Sielaff
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Regina Dicke
(Address) 1825 E 32nd St

NOV 1 1924 ROBERT R. KRAUTER, Asst. Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 12th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8 1924 to Nov. 12 1924 that I last saw him alive on Nov. 12 1924 and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis - Acute -
Peritonitis - Local -

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 2 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? 1825 E 32nd St.

Did an operation precede death? Yes Date of Nov. 8, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy.

(Signed) Henry U. P. Wilson Jr M.D. M. D.
, 19 (Address) Church Home & Inf.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cem — DATE OF BURIAL. Nov 16 1924

20-UNDERTAKER. George Schulling & Sons — ADDRESS 126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D 91953

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp. WARD) 20

2-FULL NAME Baby Bauman

(a) RESIDENCE NO. 2589 W. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12 1924

7 AGE: Years ..... Months ..... Days 1 — If LESS than 1 day ..... hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Jays Bauman

11 BIRTHPLACE OF FATHER (city or town) Balt. Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Eddye Cox

13 BIRTHPLACE OF MOTHER (city or ~~town~~) .....
(State or country)

14 Informant Mrs. John J. Bauman
(Address) 2589 W. Fayette

15 NOV 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1924, to Nov 13, 1924, that I last saw him alive on Nov 13, 1924, and that death occurred, on the date stated above, at 4:00 Am.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Dempsey M. D.

19 (Address) 1111 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Nov 14 1924

20 UNDERTAKER: Geo Leimbachs Son

ADDRESS: 647 W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91954

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 9 E. Henrietta Street St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Christina Klein

(a) Residence No. 9 E. Henrietta Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~, HUSBAND of (or) ~~WIFE~~ of Late Henry Klein

6-DATE OF BIRTH (month, day and year) Apr. 2, 1852

7-AGE, 72 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Harmony

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophia Dryer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant Mrs. Louis Hoot

(Address) 904 Light Street

NOV 1 3 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 12, 1924

17-I HEREBY CERTIFY, That I attended deceased from Sept 16 1924 to Nov 12 1924

that I last saw h.. alive on Nov 12 1924,

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Valve Heart Disease

Lt. Interstitial Nephritis

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? 25th York Road

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologic examination

(Signed) George A. E. Hogben, M. D.

11-12 24 (Address) 10 N. Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov 14 1924

20-UNDERTAKER, Joseph B Cook ADDRESS 1003 W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 91955

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 91955

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N. Chas. St ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Susan Melvin Stewart

(Residence in Baltimore: No. 2200 Maryland Ave; Md. Ave 5 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 4, 1859 (Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 8 da.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Anderson W. Melvin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Smith

13-BIRTHPLACE OF MOTHER (State or Country), Del

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. K. Sisco

(Address) 1315 N. Chas St.

15 NOV 1 31924 191 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4, 1924, to Nov. 12 1924, that I saw her alive on Nov. 12 1924, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) yrs. 1 mos. 8 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) H. K. Sisco M. D.

, 191... (Address) 1315 N. Chas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 6 da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Chesterlown, Md. DATE OF BURIAL. 11/15, 1924

20-UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

Via Automobile to Bay Shore 500 Ferry in Auto Hearse - Escort David B. Stewart

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cer.—1-12-2?—M&T—100 Bks.

D 91956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 74001

D 91956

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earle S. Dashiell

(a) RESIDENCE No. Sparks, Balto. Co., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Wells

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	0	12	

8 OCCUPATION OF DECEDENT
(a) Trade, profession or particular kind of work Mfgr. of Chocolates
(b) General nature of industry, business, or establishment in which employed (or employer) Nelson-Dashiell Co.
(c) Name of employer

886

9 BIRTHPLACE (city or town) Wycomico Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Nathaniel P. Dashiell

11 BIRTHPLACE OF FATHER (city or town) Wycomico Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Robinson

13 BIRTHPLACE OF MOTHER (city or town) Wycomico Co.
(State or country) Maryland

14 Informant Walter Wells
(Address) 117 E. 25th. St.

15 Filed NOV 13 1924, 192 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Cerebral Hemorrhage

Duration (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) M. M. Valley, M. D.
(Coroner.)
Nov 13, 1924 (Address) 10 E Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) ten months
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	11/14 1924

20 UNDERTAKER Henry W. Mears & Son ADDRESS 845 N Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91957

CERTIFICATE OF DEATH.

101-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 318 S. Washington St. St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. O'Brien

(a) Residence No. 318 S. Washington St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna O'Brien

6-DATE OF BIRTH (month, day and year) Aug. 13, 1885

7-AGE. 39 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Rigger

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Transferring Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER Patrick J. O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Sarah O'Boyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14- (Informant) Anna O'Brien

(Address) 316 S. Washington St.

15- Filed ..... 192.... Robert P. Harrison, Registrar.

NOV 13 1924 Asst. Deputy Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 11, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov. 4 19 24 to Nov 11 19 24

that I last saw h— alive on Nov 11 19 24

and that death occurred, on the date stated above, at 11.45 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia —
(Acute Bronchitis followed by Lobar P.)

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure —

(Duration) ....yrs. ....mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Harper Brandau M. D.

Nov 12. 1924 (Address) 125 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 14, 1924
20-UNDERTAKER. H. Sander Sons	ADDRESS 1710 Eutaw St

B—WRITE PLAINLY, WITH UNFADING INK—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Francke)

D 91958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91958

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

Registered No.....

City of BALTIMORE: (No.....St.,.....6.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Francke

(a) Residence No. 421 N. Linwood Ave St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Francke

6-DATE OF BIRTH (month, day and year) Dec 16, 1877

7-AGE. 46 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)..... 008

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country)..... Md

PARENTS.

10-NAME OF FATHER. Julius Francke

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Kern

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14-(Informant)..... Katherine Francke
(Address)..... 421 N. Linwood Ave

15-Filed NOV 3 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 12-24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1924 to Nov. 12th 1924, that I last saw him alive on Nov. 12th 1924, and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma General

(Duration) —— yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? 421 N Linwood Ave Balto

Did an operation precede death? Yes Date of Oct. 28, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Keith S. Rider, M. D.

19 (Address) Church Home & Inf.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery

DATE OF BURIAL. Nov. 15 1924

20-UNDERTAKER. H. Sander Sons

ADDRESS 1710 Eutaw St.

WRITE PLAINLY, WITH UNFADING INK. This is a PERMANENT RECORD. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Spec.—1-10-21—M&T—1500 Blks.

D 91959

HEALTH DEPARTMENT—CITY OF BALTIMORE D 91959

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Baby (girl) Pinnett

(a) RESIDENCE NO. Westminster Md ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13-24.

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newborn Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) M. Hospital Baltd. Md

PARENTS

10 NAME OF FATHER George Cyril Pinnott

11 BIRTHPLACE OF FATHER (city or town) Westminster (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Lantz

13 BIRTHPLACE OF MOTHER (city or town) Westminster (State or country) Md

14 Informant Hospital Record
(Address) .....

15 Robert P. Harrison, Registrar
NOV 13 1924 ..... 19 .....
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924 to Nov 13, 1924, that I last saw h/he alive on Nov 13, 1924, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) P. Smoot, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL 11/13/24

20 UNDERTAKER Boyd & Staley Feltwell — ADDRESS .....

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91960

D 91960

CERTIFICATE OF DEATH.

161-08

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST., W WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby (boy) Sinnott.

(a) RESIDENCE NO. Westminster Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Newborn Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/13/24

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 20 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Newborn Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Mercy Hospital Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George Cyril Sinnott

11 BIRTHPLACE OF FATHER (city or town) Westminster
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Lantz

13 BIRTHPLACE OF MOTHER (city or town) Westminster
(State or country) Md.

14 Informant Hosp Record
(Address) .....

15 Filed ..... 19 ..... Registrar .....
Robert P. Harrison,
Burial Permit Clerk

NOV 13 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13/24 19 17

I HEREBY CERTIFY, That I attended deceased from Nov. 13 19 24 to Nov. 13 19 24.
that I last saw him alive on Nov. 13 19 24.
and that death occurred, on the date stated above, at 10 00 a.m.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) P. J. Sinnott, M. D.
..... 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL 11/15/24 19

20 UNDERTAKER Engel & Lesley Sutton & Snyder — ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY

Spec.—1-10-21—M&T—1500 Bks.

D 91961 HEALTH DEPARTMENT—CITY OF BALTIMORE D 91961

1753 + 65 - 801

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Blair

(a) RESIDENCE NO. R. F. D. #2. ST., Elkton, Md WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Bertha Wiseman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Record
(Address) Johns Hopkins Hospital

W 1 3 1924 . 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1924, to Nov 12, 1924, that I last saw him alive on Nov 12, 1924, and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Aug Jacobaeus, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton Md	11/13 1924
20 UNDERTAKER	ADDRESS
Joseph Abrens	22 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—I-10-21—M&T—1500 Bks.

D 91962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Grimes

(a) RESIDENCE NO. 108 N. Lakewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 9, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Grymes

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mildred .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records
(Address) .....

CV 1 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1924, to Nov 11, 1924, that I last saw her alive on Nov 11, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity with congenital hare lip and cleft palate

(duration) life yrs. 8 mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mon. 11 ds.

18 Where was disease contracted if not at place of death? Pneumonia in Hosp.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edwyn A. Kreper, M. D.

11/25, 1924 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Earlwood Cem	11/14/24 19
20 UNDERTAKER Geo J Roth	ADDRESS 1735 Hanford

CB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 91963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91963

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 E. Lee ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margret Doyle

(a) RESIDENCE. NO. 15 E. Lee St ST., 22 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Doyel

6 DATE OF BIRTH (month, day, and year) Feb 5 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) County Cork, Ireland

10 NAME OF FATHER Patrick Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellen Harrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael Doyle.
(Address) 15 E. Lee St.

15 Filed NOV 13 1924. 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924, to Nov. 12, 1924, that I last saw h- alive on Nov. 12, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) C. S. Eichenbaum, M. D.

(Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 15 1924

20 UNDERTAKER ADDRESS

Wm G Schaffer 1816 E. Monument

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91964

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 142 (St.) N. Virginia Ave (Ward) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth McDonald Landon

(a) RESIDENCE No. 142 N. Virginia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	4	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. L. Landon.

11 BIRTHPLACE OF FATHER (city or town) Somerset Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sue H. Ford.

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.
(State or country) Maryland

14 Informant Sue H. Ford.
(Address) 142 N. Virginia Ave

15 Filed NOV 3 1924, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924, to Nov 13, 1924, that I last saw him alive on Nov. 13, 1924 and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

Toxic degeneration of Pneumogastric nerve & Heart paralysis. (duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) James S. Aldhurst, M. D.

11-13, 1924 (Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Nov 14 1924

20 UNDERTAKER: A. E. Hughes — ADDRESS: 4711 Broadway

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91965

CERTIFICATE OF DEATH.

D 91965

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1709 E 32nd St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George F. Plentje

(a) Residence No. 1709 E 32nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eva J. Plentje

6-DATE OF BIRTH (month, day and year) May 3. 1861

7-AGE. 63 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frederick W. Plentje

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Richard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) George F. Plentje

(Address) 1709 E 32nd St

15- NOV 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 12/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1923 to Nov. 12, 1924 that I last saw him alive on Nov. 11 1924 and that death occurred, on the date stated above, at 11.20 A. m. The CAUSE OF DEATH* was as follows:

Aortic + Mitral Regurgitation and Chronic Nephritis (Interstitial)

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. L. Mikesell, M. D.

11/13, 1924 (Address) Rosemary Balt., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Western Cem. DATE OF BURIAL, Nov. 14, 1924

20-UNDERTAKER. Mrs. John H. Seifel & Son ADDRESS 601 W. Fayette St.

N. B.—WHITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Girl

D 91966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91966

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balt General Hospital ST., ... WARD)

2-FULL NAME Roland Phillip Fiol

(a) RESIDENCE NO. Lansdowne Rd ST., ... WARD Lansdowne

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov 20 1922

7 AGE — Years: 1 — Months: 11 — Days: 22 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balt.

PARENTS

10 NAME OF FATHER: John M Fiol

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Stickel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. John Fiol

(Address) 128 Laverne Ave

15 NOV 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov 5, 19 24, to Nov 12, 19 24,

that I last saw h[illegible]live on Nov 12, 19 24,

and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Bi Lateral Mastoiditis with Septicemia

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Otitis Media,

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 12/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Labor[illegible]

(Signed) J. A. Zierler, M. D.

Nov 15 19 24 (Address) 102 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: Nov 14 1924

20 UNDERTAKER: Wm Fickus & Sons

ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91967

CERTIFICATE OF DEATH.

D 91967

Graves

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 413 Hollen Road ST. (WARD) 27

2-FULL NAME Bertha Baugher

(a) RESIDENCE (No.) 413 Hollen Road ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: John Fredk Baugher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eva Winchester

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mrs. B. R. Baugher. (Address) 413 Hollen Rd.

15 Filed NOV 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1924, to Nov 12, 1924, that I last saw h[illegible] alive on Nov 12, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver Following removal of breast 1 year ago.

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. H. Hoodless, M. D.

, 19 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Cem — DATE OF BURIAL: Nov 14 1924

20 UNDERTAKER: Wm J Pickney Sons — ADDRESS: Norbeth Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D 91968

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 N. Biddle St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Magelt

(a) Residence No. 209 N. Biddle St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1897

7-AGE, 27 yrs. — mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N. C.

PARENTS.

10-NAME OF FATHER Mike Magelt

11-BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12-MAIDEN NAME OF MOTHER, Ellen Dempsey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14-(Informant) Louis Magelt

(Address) 209 N. Biddle St

15-Filed NOV 14 1924 ROBERT R. KRAUTH, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-13-24

17- I HEREBY CERTIFY, That I attended deceased from Sep. 26 1924 to Nov. 13 1924

that I last saw her alive on Nov 12 1924

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no. Clinical Exam

(Signed) Frank Krampf M. D.

11/13, 1924 (Address) 1906 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem — DATE OF BURIAL, 11-15-1924

20-UNDERTAKER David Easton — ADDRESS 916 Penna ave

E.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-00 D 91969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 16 WARD)

2-FULL NAME Chester Overton

(a) RESIDENCE NO. 1202 Harlem Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Overton

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 023

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffeur

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record.

(Address)

NOV 14 1924

Filed , 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/24

17

I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924 to 11/11/24, 19 .

that I last saw h alive on 11/11/24, 19 .

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	11/17/24
20 UNDERTAKER	ADDRESS
Mrs. P. C. Elbert	172 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91970

CERTIFICATE OF DEATH.

123D 91970

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals St. Boyd Ward 17)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah Williams

(a) Residence No. 1321 Myrtle Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE. 41 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housemaid

(b) General nature of Industry, business, or establishment in which employed (or employer) 10 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Jamaica

PARENTS.

10-NAME OF FATHER. Jos Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Jamaica

12-MAIDEN NAME OF MOTHER. Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Jamaica

14- (Informant) Edward Stevenson

(Address) 1507 Myrtle Ave

15- Filed NOV 14 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/13/24

17- I HEREBY CERTIFY, That I attended deceased from 11/3 19 24 to 11/13 19 24

that I last saw h[illegible] alive on 11/13 19 24

and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Chronic)

(Duration) yrs. 21 mos. ds.

CONTRIBUTORY (Secondary) Partial Biliary obstruction

Common accident.

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Do not know

Did an operation precede death? Yes Date of 11/13/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Claude A. Dorsey M. D.

11-12-1924 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mt Auburn Cem	Nov. 16 1924
20-UNDERTAKER.	ADDRESS
Annie L Brindley	1 Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91971

CERTIFICATE OF DEATH.

D 91971

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1914 Druid Hill Ave. WARD 14)

2-FULL NAME Mary J. Fooks

(a) RESIDENCE NO. 1914 Druid Hill Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Salisbury Md

PARENTS

10 NAME OF FATHER: George Purnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Georgie Carter

(Address) 1914 Druid Hill Ave.

15 NOV 14 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1924. to Nov. 11, 1924.

that I last saw her alive on Nov. 11, 1924.

and that death occurred, on the date stated above, at 7-15 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis (Interstitial) (duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Nov. 14 1924

20 UNDERTAKER: Samuel Prentiss

ADDRESS: 1[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91972

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 S Broadway ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Mercer

(a) RESIDENCE NO. 25 S Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada Mercer

6 DATE OF BIRTH (month, day, and year): Sept 17 1857

7 AGE: Years 67 Months 1 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nothing

(b) General nature of industry, business, or establishment in which employed (or employer): NO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: James L Mercer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: A Bowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Ada Mercer (Address) 25 S Broadway

NOV 14 1924 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4 , 1924 , to Nov. 13 , 1924 ,

that I last saw h— alive on Nov. 12 , 1924 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) 3 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam + Urinalysis

(Signed) A T Ries, M. D.

Nov 13 1924 (Address) 24 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Berhams Warf Virginia — DATE OF BURIAL: Nov 14 1924

20 UNDERTAKER: Fisick Sylvester — ADDRESS: 1600 N North Ave

B.D.A.V.

Stec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91973

CERTIFICATE OF DEATH.

101-001

D 91973

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 N. Gilmor St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Job Herbert

(a) Residence No. 700 N. Gilmor St., Ward.....
(Usual place of Abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S., if of foreign birth? ...yrs. ...mos. ...ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. R. Herbert

6-DATE OF BIRTH (month, day and year) Feb 11 1885

7-AGE. 39 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. City Treas 009

(b) General nature of Industry, business, or establishment in which employed (or employer) R. Ramsay Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). England

PARENTS:

10-NAME OF FATHER. J. C. Herbert

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Deadma Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) Sarah J. R. Herbert

(Address) 700 N. Gilmor St

15-

Filed NOV 14 1924 19... ROBERT B. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1924 to Nov. 12 1924.

that I last saw h. alive on Nov 12 1924.

and that death occurred, on the date stated above, at 1.30P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ...yrs. ...mos. 5 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A. Evans M. D

19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem	Nov. 14 1924
20-UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91974

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D 91974

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maurice Byrne

(a) Residence No. Preston & Valley Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (~~Write the word.~~) Widow

5a-~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~Wife of~~ Mary A. Sullivan

6-DATE OF BIRTH (month, day and year) 1844.

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Sailor

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Ireland.

PARENTS.

10-NAME OF FATHER. Michael Byrne

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Welch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland.

14- (Informant) Sister F. Lawrence

(Address) Preston & Valley

15- NOV 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 12 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 24 ..... 19..... to ..... 19.....

that I last saw him alive on Nov 9 19 24

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility of old age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Nov 13 1924 (Signed) F. A. Warner, M. D. (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross	Nov. 14, 1924
20-UNDERTAKER.	**ADDRESS**
H. C. Wedefield	914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 91975

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 S 4th St. 1st WARD)

2-FULL NAME Celeste E. Hammelman

(a) RESIDENCE NO 904 S 4th ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. life mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	5	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Hammelman

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Zippel

13 BIRTHPLACE OF MOTHER (city or town) Balto City (State or country)

14 Informant Elizabeth Hammelman
(Address) 904 S. 4th St.

15 NOV 14 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) James M Benson, M. D.
(Coroner.)

Nov 12, 1924 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 14 1924

20 UNDERTAKER	ADDRESS
Lilly & Gilea	405 S. Wolfe St

Spec- 12-23-21- E.P.H.S.—400 Exs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91976

CERTIFICATE OF DEATH.

D 91976

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 2219 Essex St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Matthew Weber

(a) Residence No. 2219 Essex St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Weber.

6-DATE OF BIRTH (month, day and year) Aug 5th 1863.

7-AGE. 61 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Barber

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Joseph Weber.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant). Mary Weber

(Address) 2219 Essex St.

15-

NOV 14 1924

ROBERT R. KRAUTER, Jr. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 12th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 19.. to Nov. 12 19 24.

that I last saw h. alive on Nov 12 19 24.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. Unknown

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Jannopoulos M. D.

Nov 13, 1924 (Address) 2431 East Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL. Nov 15 1924

20-UNDERTAKER. Lilly + Zeiler — ADDRESS 4032 Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-28—M&T—100 Bks.

D 91977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Decision & Burgin ST., 30 WARD)

REGISTERED NO. 1903 1881

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman W. Ray

(a) RESIDENCE No. 2030 Boyd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14-1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk in
(b) General nature of industry, business, or establishment in which employed (or employer) Office
(c) Name of employer Balto. Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Edward B. Ray

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth L. Norton

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Edward B. Ray
(Address) 2030 Boyd St

15 Filed NOV 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

Instantly dead.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) automobile accident.
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy (Coroner.), M. D.

Nov. 12, 1924 (Address) 2 St Paul Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Nov. 14 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	320 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 91978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91978

Registered No.....

1-PLACE OF DEATH St. Joseph's Hospital 5

City of BALTIMORE: (No.....St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Butler

(a) Residence No. 1006 Low St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of married

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
46 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), —

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), —

14- (Informant) Virginia Butler

(Address) 1006 Low st

15- Filed NOV 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 12, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov 5, 1924 to Nov 12, 1924

that I last saw h. alive on Nov 12, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

with generalized Carcinomatosis

(Duration) ? yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) 28 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Sybert, M. D.

, 19 (Address) 11 John Hop.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Bury cemetery	Nov 17, 1924
20-UNDERTAKER,	ADDRESS 1631
Edward Bryan	Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Watson 2018 E Pratt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

D 91979

CERTIFICATE OF DEATH.

58 D 91979

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1815 East Fidural ST., 8 WARD)

2-FULL NAME Louisa Geller

(a) RESIDENCE NO. 1815 E. Fidural ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Geller

6 DATE OF BIRTH (month, day, and year) June 29. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Antone Stondt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Frank J Geller (Address) 1815 East Fidural St

15 Filed ... 19 ... ROBERT R. KRAUTER, Registrar

NOV 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26. 19 24. to Nov 12. 19 24.

that I last saw h[illegible] alive on Nov 12

and that death occurred, on the date stated above, at 10:43 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia -

(duration) One yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? ni

What test confirmed diagnosis? Repeated blood examinations

(Signed) Wm J Watson, M. D.

, 19 (Address) 2124 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Nov 15 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 91980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

D 91980

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520 E 26th ST.; 9 WARD)

2-FULL NAME Charles E. Hubbard

(a) RESIDENCE. NO. 520 E 26 ST., WARD. ...

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 56 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Hubbard

6 DATE OF BIRTH (month, day, and year) Dec 31 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R R Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) R R

(c) Name of employer Penn R.R. Lawton Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER James M Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Hubbard (Address) 520 E 26th St

15 Filed ..... 19 ..... Registrar

NOV 4 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to Nov 13, 1924, that I last saw him alive on Nov 11, 1924, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum 3

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) James M Watson, M. D.

(Address) 720 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Nov 15 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E Fort Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 91981

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 91981

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Frances Convent ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie E Henson

(Residence in Baltimore: No. Chase and Forest Place Age 44 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 8 (Day) 1881 (Year)

7-AGE, 43 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Providance Rhode Island

PARENTS.

10-NAME OF FATHER, Ignatius Henson

11-BIRTHPLACE OF FATHER (State or Country) Port Tobacco Md.

12-MAIDEN NAME OF MOTHER Louise Simms

13-BIRTHPLACE OF MOTHER (State or Country) Port Tobacco Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother M. Thaddeus O.S.C.

(Address) St Frances Convent Chase & Forest Place

15- NOV 14 1924 191 ROBERT B. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 11 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1924, to November 1924, that I saw h[illegible] alive on Nov 11 1924, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Mitral Insufficiency

Mitral (Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Coma 24 hrs

(Duration) yrs. mos. ds.

(Signed) Mary F. Vaeglum M. D.

Nov 13., 1924 (Address) 1.10.28 Wesley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Barneyley Cemetery DATE OF BURIAL. Nov 15 1924

20-UNDERTAKER Mrs R A Elliott ADDRESS 1735 Ashland ave

N.B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91982

CERTIFICATE OF DEATH.

D 91982

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Race ST. 23 WARD)

2-FULL NAME Cornelia P. Brethauer

(a) RESIDENCE No. 1505 Race ST., 23 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced (or) WIFE of John Brethauer

6 DATE OF BIRTH (month, day, and year) — — 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Brethauer

(Address) 1505 Race St.

15 Filed NOV 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Nov 12, 1924,

that I last saw h alive on Nov 12, 1924,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) Indefinite yrs. mos da.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell, M. D.

Nov 13, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 11/14 1924

20 UNDERTAKER John J. Fahey Wood

ADDRESS 191 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91983

CERTIFICATE OF DEATH.

74 D 91983

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1162 Low St ST., 5 WARD)

2-FULL NAME Florence Chester (Lee)

(a) RESIDENCE No 1162 Bow St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George D. Chester

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Zenith DeCourcey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Chester
(Address) 1209 St James St

15 NOV 14 1924 ROBERT R. KRAUTER Registrar
Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov11/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Subdural-occip.)

Autopsy by Dr. H.J.Maldeis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Inquest Nov 14/24 (duration) ... yrs. ... mos. ... ds.

(Signed) J S H Collins (Coroner), M. D.

11/13/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Nov 15 1924

20 UNDERTAKER Mrs Lee G. Bailey — ADDRESS Jefferson St

N. B.—WRITE PLAINLY. NO ABBREVIATIONS. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91984

CERTIFICATE OF DEATH.

31 D 91984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay view Hospital 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Lunde

(a) RESIDENCE NO. 807 E Lombard ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Police Depart,
(Address)

15 Filed NOV 14 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

339

1941 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) James M Fenton, M. D.
(Coroner.)
Nov 12 1924 (Address) 707 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

Commissioner of Health, THE MORGUE, RUSSELL.

NOV 14 1924

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91985

D 91985 CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Hospitals at Bay View (Ward) Ward 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Woody

(a) Residence No. Bay View Asylum St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced: (Write the word) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1856

7-AGE: 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: Geo Woody

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14- (Informant) C. H. Jensen

(Address) Bay View Hospital

NOV 14 1924 ROBERT R. KRAUTH, Registrar.

Bldg. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11/10/24

17- I HEREBY CERTIFY, That I attended deceased from 7/14 1924 to 11/10 1924

that I last saw h.e alive on 11/10 19 24

and that death occurred, on the date stated above, at 5 40 a m.

The CAUSE OF DEATH* was as follows:

Multiple scalded & fractures (generalized)

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/19/24

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Clinical

(Signed) Clarke D. Dean, M. D.

11-10 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, 19....

20-UNDERTAKER: Dept. of Health.

ADDRESS NOV 14 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

346

Spec.—1-10-21—M&T—1500 Blks.

D 91986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91986

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 E Montgomery ST., 27 WARD)

2-FULL NAME Charles H Harries

(a) RESIDENCE No. 221 E Montgomery St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary J Harries

6 DATE OF BIRTH (month, day, and year) March 12-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways & Elec Co

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER John Harries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Sarah Davies

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Mary J Harries

(Address) 221 E Montgomery

DEC 14 1924

Robert P. Harrison
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1924, to Nov 13, 1924, that I last saw h/she alive on Nov 12, 1924, and that death occurred, on the date stated above, at 2:25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) H. H. Burton, M. D.

11/13 - 1924 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Nov 17, 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91987

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 91987

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 E Eager ST., 10 WARD)

2-FULL NAME Margaret A. Myers

(a) RESIDENCE NO. 1231 E Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? Sept yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 6 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed at Office

(b) General nature of industry, business, or establishment in which employed (or employer) Straw Hat factory

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jesse E. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna M. Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna M. Myers

(Address) 1231 E Eager St

15 Filed ....., 19.... Robert F. Harrison, Registrar

Burial Permit Clerk.

NOV 4 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Nov. 13, 1924.

that I last saw h[illegible] alive on Nov 13 1924.

and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Volvulus (History)

Stenosis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Arthur Levy, M. D.

11/5/24 (Address) 1202 E. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 15 1924
20 UNDERTAKER	ADDRESS
Henry Hoch Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 91988

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-006 91988

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4200 Harford Terrace ST., 27 WARD)

2-FULL NAME Mary Theresa Moeller

(a) RESIDENCE No. 4200 Harford Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. 6 mos. ~ ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 6 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City.

PARENTS

10 NAME OF FATHER Andrew Moeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Power

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Frances M. Burger
(Address) 4200 Harford Terrace

NOV 14 1924 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th, 1924, to Nov 14th, 1924.
that I last saw her alive on Nov 13th, 1924,
and that death occurred, on the date stated above, at 6.45 A. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) L. L. Cosby, M. D.

11-14, 1924 (Address) 218 Hoffman Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 17 1924
20 UNDERTAKER	ADDRESS
Henry Heath Son	1301 E Eager St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

D 91989

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Frederick Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Getzendanner

(a) RESIDENCE NO. 319 N Monroe St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced (or) WIFE of Thomas J Getzendanner

6 DATE OF BIRTH (month, day, and year) March 7, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Wohlen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas J Getzendanner

(Address) 319 N Monroe St

15 FILED NOV 14 1924 19

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 , 19 24 , to Nov 12 , 19 24 , that I last saw her alive on Nov 11 , 19 24 , and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Earl V. Lovelace, M. D.

19 (Address) 244 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Nov. 15 1924

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2178 Pace

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 18 WARD)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar W. Vogel

(a) RESIDENCE NO. 817 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 21. 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Building dept.

(c) Name of employer Consolidated Gas Electric Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Weigand Vogel.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Pauline Timmerding

13 BIRTHPLACE OF MOTHER (city or town) Germany.

(State or country)

14 Informant University Hospital Records.

(Address)

15 Filed NOV 14 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1924, to Nov. 13, 1924, that I last saw him alive on Nov. 13, 1924, and that death occurred, on the date stated above, at 9.50 p. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis.

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

Empyema (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 5. 1924

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) M. Edwards, M. D.

, 19 (Address) University Hospital Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Nov 17-24

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2872 Oak

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1011 Stiles St. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary DeSanctis

(a) Residence No. 1011 Stiles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Anthony DeSanctis

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Alexander Trotta

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary Laura

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Mary DeSanctis

(Address) 1011 Stiles St

15- Filed NOV 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 11. 1924.

17- I HEREBY CERTIFY, That I attended deceased from November 1 19 24 to November 11 19 24

that I last saw h[illegible] alive on November 11 19 24

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

General breakdown due to senility

(Duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Red Cgl

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 1 N St Louis

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. West Holy Redeemer — DATE OF BURIAL. Nov 16 1924.

20-UNDERTAKER. Wendel & Rippert Inc — ADDRESS 3 J & Lombard

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 91992

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91992

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mt Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Harry Jennemon

(a) Residence No. Mt Hope Retreat St.,..... Ward.....

(Usual place of nbode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Aug. 11. 1850

7-AGE, 74 yrs. 3 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Dedrick Jennemon

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Susan Koch

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Pennsylvania

14-

(Informant)..... Mt Hope Friends

(Address).....

15-

Filed ..... 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 13. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Nov. 13, 1924, that I last saw h.. alive on Nov. 11, 1924, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion + Senility

Unknown (Duration)..... yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical

(Signed) Milton P. Dill, M. D.

, 19 (Address) Wyle Av + Rockeby Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Peters Cemetery

DATE OF BURIAL, Nov 15. 1924

20-UNDERTAKER. F.A. Krause & Son

ADDRESS 703 Hanover

NOV 14 1924

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91993 **HEALTH DEPARTMENT—CITY OF BALTIMORE** VD 91993

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1148 Washington Blvd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth H Lawlor

(a) Residence No. 1148 Washington Blvd Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John G. Hanlon

6-DATE OF BIRTH (month, day and year) Jan 5-1854

7-AGE. 70 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer). at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto ?

PARENTS.

10-NAME OF FATHER, ? Greib

11-BIRTHPLACE OF FATHER (city or town) (State or Country). not given

12-MAIDEN NAME OF MOTHER, not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). not given

14- (Informant) Caroline C. Wesing

(Address) 3704 Greenmount Ave

15- FILED NOV 14 1924 Robert P. Harrison, 19?..... Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 12-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 19 24 to Nov 12 19 24

that I last saw h-- alive on Nov 11 19 24

and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Engelhardt M. D

11/13 19 24 (Address) 5 E Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Nov 15. 1924

20-UNDERTAKER, F. A. Krause & Son — ADDRESS 703 Hanover

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 91994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91994

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST., 28 WARD)

2-FULL NAME Alexander P. Renfro.

(a) RESIDENCE NO. 4101 Lloyd Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alexander P. Renfro.

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hart County, Kentucky

PARENTS

10 NAME OF FATHER Eliza Thomas Renfro

11 BIRTHPLACE OF FATHER (city or town) Kentucky (State or country)

12 MAIDEN NAME OF MOTHER Mary Sidler

13 BIRTHPLACE OF MOTHER (city or town) Kentucky (State or country)

14 Informant Lillie M. Renfro (Address) 4101 Lloyd Ave

15 Filed NOV 14 1924, 19 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov - 8, 1924, to Nov 13, 1924, that I last saw him alive on Nov. 13, 1924, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart. 15 hours

Relative aortic and mitral insufficiency. over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic aneurism. 6? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? none Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) Jno A Thompkins, M. D.

, 19 (Address) 1117 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooklyn N. Y.	Nov 15 19 24
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Mt Royal Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91995

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 White Ave. Raspeburg St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice E. Jones

(a) Residence No. 104 White Ave. Raspeburg St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) Sept. 25, 1862

7-AGE. 62 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Alfred H. Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Annapolis, Md.

12-MAIDEN NAME OF MOTHER, Sarah J. Gray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore, Md.

14- (Informant) Emma C. Jones

(Address) 104 White Ave. Raspeburg

15- Filed ..... 192 ..... Registrar.

NOV 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23 1924 to Nov. 13 1924

that I last saw h... alive on Nov. 8 1924

and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

6

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

11/13 1924 (Signed) Chas S Mech M. D.

(Address) 405 Park Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL. Nov. 15 1924

20-UNDERTAKER. H. Sander & Sons — ADDRESS 1710 Fleet St

IN B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 91996 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 91996

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 N Eden ST., 10 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Haacke

(a) RESIDENCE No 1217 N. Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lif yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sybilla Haacke

6 DATE OF BIRTH (month, day, and year) July 26/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Highway Engineer
(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Christopher Haacke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Osterhaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sybilla Haacke
(Address) 1217 N. Eden St

15 Filed NOV 14 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insuffiviency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. ds.

(Signed) H. H. Porter, M. D.
(Coroner.)

Nov 14/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
(Where was disease contracted, if not at place of death?)

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov. 15 1924
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Pred St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 91997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 91997

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1441 Washington Boulevard ST., 90 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Gutheil

(a) RESIDENCE No 1441 Washington Boulevard ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 20 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Emma Coleman
(Address) 1441 Washington Boulevard

15 Filed ... 192 Robert P Harrison, Registrar

NOV 14 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 = 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by an Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

½ hour (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Thos B. Horton, M. D.
(Coroner.)

, 192 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 15 1924

20 UNDERTAKER Woolcook & Son & Towles ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91998

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

D 91998

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 345 Whitridge Avenue St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Virginia Webber

(a) Residence No. 345 Whitridge Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred G. Webber

6-DATE OF BIRTH (month, day and year) Sept 18, 1896

7-AGE. 28 yrs. 0 mos. 23 ds.

If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Brooklyn M.A. Co. Md

PARENTS.

10-NAME OF FATHER. Benjamin Hergt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elizabeth Tannell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Alfred G. Webber

(Address) 345 Whitridge Ave.

15- Filed NOV 14 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 11-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8 1924 to Nov. 11 1924

that I last saw her alive on Nov. 11 1924

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficency 1

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual Symptoms

(Signed) Wm. J. Pikesley M. D

(Address) 1356 Edgewood Road

Nov. 13. 1924

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cemetery

DATE OF BURIAL. Nov 15, 1924

20-UNDERTAKER. E. LeRoy Steffler

ADDRESS 125 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

NOV 14 1924 Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 91999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 91999

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1426 Richardson St., 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Schaechtel

(a) Residence No. 1424 Richardson St., 34 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/7/24

7-AGE. yrs. 9 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Edw. Schaechtel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Barbara Breckman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant). Edw Schaechtel

(Address) 1426 Richardson

15- 2nd 192 Robert P. Harrison, Registrar.

NOV 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 14 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2nd 1924 to Nov 14 1924

that I last saw him alive on Nov 14 1924

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diarrhea & Enteritis

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ordinary tests

(Signed) A. Wroblewski M. D.

11-15 1924 (Address) 2202 W North

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross Cem	11/15/24
20-UNDERTAKER.	ADDRESS.
J. J. Bailey & Sons	1318 Light St.

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Misc. 1-10-21 M&T 1500 Blks.

D. 92000

D 92000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 92000

90 D 92000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Glenwood Av ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret N. Howard

(a) RESIDENCE No. 1514 Glenwood Av ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grayson Howard

6 DATE OF BIRTH (month, day, and year) July 12-1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
28 yrs	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alexander Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise J Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grayson Howard

(Address) 1514 Glenwood Ave

15 Filed NOV 14 1924 Robert P. HARTIGAN, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1924 to Nov 12 1924, that I last saw her alive on Nov 12 1924, and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jason Druckman M.D.

11/13 1924 (Address) 846 W 36 681

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Balto Co DATE OF BURIAL Nov 16 1924

20 UNDERTAKER Chenoweth Son ADDRESS 3617 Chestnut Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

92001
D 92001

HEALTH DEPARTMENT—CITY OF BALTIMORE

92001
D 92001

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 130 S. Curley St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Deinlein

(a) Residence No. 130 S. Curley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6-DATE OF BIRTH (month, day and year): Sept 30 1884

7-AGE: 40 yrs 1 mos ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Saloon
(b) General nature of industry, business, or establishment in which employed (or employer): Own
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.
10-NAME OF FATHER: George Deinlein
11-BIRTHPLACE OF FATHER (city or town) (State or Country): City
12-MAIDEN NAME OF MOTHER: Coetzey
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) J. Moran
(Address) 3000 E Baltimore

Filed 1924 Robert P. Harrison, Registrar.

NOV 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-12-24

17- I HEREBY CERTIFY, That I attended deceased from May 1—24 to 11-12-24 that I last saw him alive on 11-12-24 and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) F. Ford Burton M. D.

19 (Address) 2060 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 15 19 24

20-UNDERTAKER: J. J. Moran — ADDRESS 3000 E Baltimore

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

92002

D 92002

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

100 001 92002

D 92002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 Bartlett Ave ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Salafia

(a) RESIDENCE NO. 654 Bartlett Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Salafia

6 DATE OF BIRTH (month, day, and year) March 18, 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Bucchere

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Paula D'orgo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Salafia

(Address) 654 Bartlett Ave

15 NOV 15 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 5, 1924, to Nov 13, 1924

that I last saw her alive on Nov 13, 1924

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DeStefano M. D.

Nov 14, 1924 (Address) 407 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Nov 16 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1730 Harford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—(2-23-21—E.B.R.S.—40M) Bks.

92003 D 92003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92003 D 92003

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1706 E Federal St St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent LeRoy Cole

(a) Residence No. 1706 E Federal St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11/9/24.

7-AGE. ... yrs. ... mos. 5 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None old

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Elmer Cole

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary Whelan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Elmer Cole

(Address) 1706 E Federal St

15- Filed ... Robert P. Harrison, Registrar.

NOV 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 14th 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1924 to Nov 14 1924

that I last saw him alive on Nov 14 1924

and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia (Lobar)
Right Lower Lob

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ... yrs. ... mos. 1/6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Thos E Geraghty M. D.

11/14/24 19 (Address) 703 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cemetery	Nov 16 1924
20-UNDERTAKER.	**ADDRESS**
Geo. J. Roth.	1335 Hanford Ave.

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

92004 / 92004

D 92004 HEALTH DEPARTMENT—CITY OF BALTIMORE 1/2 D 92004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Strieker ST., 19 WARD)

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Anthony

(a) RESIDENCE No. 410 N Strieker ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maggie Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Anthony (Address) 410 N Strieker St

NOV 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924, to Nov 13, 1924, that I last saw him alive on Nov 13, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey M. D.

11/14, 1924 (Address) 1928 Fenwal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Nov. 15 1924

20 UNDERTAKER Chris. H. Johnson ADDRESS 716 N. Caroline St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92005 — CERTIFICATE OF DEATH — D 92005

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Elm Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E Tair

(a) RESIDENCE. No. 3503 Elm Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Abdiel M Tair

6 DATE OF BIRTH (month, day, and year) June 5-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. M Tair
(Address) 3503 Elm Ave

15 Filed ..., 19 Robert P. Harrison, Registrar

NOV 15 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1924, to Nov 12, 1924, that I last saw her alive on Nov 12, 1924, and that death occurred, on the date stated above, at 6 55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart Disease

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular - Intestinal Resection (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept. 16, 24

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo Wash Off M. D.

11/12/1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov 15 1924
20 UNDERTAKER Franklin W Seitz	ADDRESS 7-9 W 33d

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92006 HEALTH DEPARTMENT—CITY OF BALTIMORE 92006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital 6 100-00 Registered No.....

City of BALTIMORE: (No..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Miller

(a) Residence No. 1749 Mulliken St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of Industry, business, or establishment in which employed (or employer) 037
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do. Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do. Do.

14- (Informant) Bay View Hospital
(Address) Balto., Md.

15- Filed NOV 15 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/13/24

17- I HEREBY CERTIFY, That I attended deceased from 9/13/ 1924 to 11/13/ 1924
that I last saw her alive on 11/12/ 1924
and that death occurred, on the date stated above, at 5.45a m.
The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab + Clinical findings

(Signed) N. Goldsmith M. D.

11/14/ 1924 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Ashley Co. DATE OF BURIAL, 11/15/24. 10 2PM

20-UNDERTAKER. Byron Wright ADDRESS 1218 McCulloh

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92007 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 161-001

City of BALTIMORE: (No. 2426 Mt Pleasant Av St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian E Conners

(a) Residence No. 2426 Mt Pleasant, St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Nov 1876

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Paul H. Conners

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mildred M Foltz

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Balto

14- (Informant) Paul H. Conners

(Address) 2426 Mt Pleasant Av

15- Filed ..... Robert P. Harrison, Registrar.

NOV 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1924, to Nov 15, 1924, that I last saw h. Sv. alive on Nov 14, 1924, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Lumbago,

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic

8 mo (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ..... Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. J. Spencer, M. D.

11/25, 1924 (Address) 330 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cem	Nov 15, 1924
20-UNDERTAKER. John Meier	ADDRESS 2008 Orleans

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter S. Milne

(a) RESIDENCE No. Signal Dr Chattanooga Tenn WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mrs. Walter S. Milne

6 DATE OF BIRTH (month, day, and year) Sept 27th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Milne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Eliza Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 NOV 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from Novem 7th, 1924, to Novem 14th, 1924, that I last saw him alive on Nov 14th, 1924, and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Ch. Rheumatic Endocarditis
Acute Fibrillation,
Cerebral Embolism

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Nobody Knows

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. Ch. Lovenberg M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chattanooga Tenn	Nov 15 1924
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Son Co	Oakland

Srec—12-23-21—E.B.R.S.—400 Eks.

D 92009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92009

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Jos Hospital Baltimore

Registered No.....

City of BALTIMORE: (No.....St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frances Handloser.

(a) Residence No. 2 Halcyon Park road St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Late Lorenz Handloser

6-DATE OF BIRTH (month, day and year) Dec 18/50

7-AGE, 73 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Henry L. Handloser

(Address) 2 Halcyon Park road

15-Filed ....., 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 15 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/14/24

17-I HEREBY CERTIFY, That I attended deceased from Oct 18th 1924 to Nov 14 1924, that I last saw her alive on Nov 14 1924, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency. Edema Lungs. (Duration) ....yrs. ....mos. 1 ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of Nov 13/24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H. B Sybert, M. D.

, 19 (Address) St. Jos Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL, 11/17, 1924

20-UNDERTAKER. Philip Herrig — ADDRESS 2006 Eutaw

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92010

CERTIFICATE OF DEATH.

11-001

D 92010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 N. Fremont Ave ST.) 14 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Curtis

(a) RESIDENCE No. 1401 N. Fremont Ave ST. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Curtis

6 DATE OF BIRTH (month, day, and year) July 13, 1793

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Brooks

(Address) 1463 Pierce Ave

15 Filed NOV 15 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13. 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 7. 1924, to Nov 12. 1924, that I last saw him alive on Nov 12. 1924, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. L. Davis, M. D.

(Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 15 1924

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 Carey St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92011 D 92011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

2-FULL NAME Philip T. Minor

(a) RESIDENCE NO. 3227 Brighton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Flossie Minor

6 DATE OF BIRTH (month, day, and year) Aug 14. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Agent

(b) General nature of Industry, business, or establishment in which employed (or employer) 071

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Minor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Moody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Record (Address) Union Memorial Hos.

15 Filed NOV 15 1924, 19 Robert P. Harriden, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 24. to Nov 14, 19 24.
that I last saw h alive on Nov 14, 19 27.
and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum, Colon, intestines

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Sept 7, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation—

(Signed) A.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 17, 1924

20 UNDERTAKER J. Frederick Sons ADDRESS North St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 811 McDonough St., 7 Ward)

Registered No. 112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Chesselhow

(a) Residence No. 811 McDonough St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: C

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of): Married

6-DATE OF BIRTH (month, day and year): unknown

7-AGE: Years: about 50 yrs Mos. Ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (City or Town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14-

(Informant): Mrs Robt A Elliott (undertaker)

(Address): 1925 E Ashland Ave

15-

Filed: Robert P. Harrison, Registrar.

NOV 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 19 24 to Nov 12 19 24

that I last saw h. alive on Nov 12 19 24

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Acute Gastritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R F Young M D

19 (Address) 172 E Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenwood c. Va	Nov. 15, 1924
20-UNDERTAKER	ADDRESS
Mrs R. A. Elliott	1925 Ashland Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92013

CERTIFICATE OF DEATH.

16-08 D 92013

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Summers

(a) RESIDENCE NO. 1615 S. Eugene St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1924

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel LeCompte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital

15 NOV 15 1924 Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct-15- , 1924, to Oct-16 , 1924,

that I last saw h[illegible] alive on Oct-16 , 1924,

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) Charles H. Peffhouse, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

[illegible]NS HOSPITAL 19

20 UNDERTAKER ADDRESS.

Bureau of Vital Statistics NOV 13 1924

MARGIN RESERVED FOR BINDING

D.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92014

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D 92014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. near Franklin & Carrie Ave WARD) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anton Szlagitis

(a) RESIDENCE No 1519 E. Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Interperter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Paul Sinkiwich
(Address) 608 W. Balto. Md

15 Filed NOV 15 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 or 12th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

a Strangulation by hanging-suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Paten, M. D.
(Coroner.)

11/15/24. 192 (Address) 508 E. North Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov. 15 1924

20 UNDERTAKER Richard F. Cuskey — ADDRESS 1108 Guilford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92015

CERTIFICATE OF DEATH.

REGISTERED NO. 74-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Clifton av ST., 15 WARD)

2-FULL NAME Alfred E. Herkenheim

(a) RESIDENCE NO. 1823 Clifton av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Carl Herkenheim

6 DATE OF BIRTH (month, day, and year) Mar 20-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer) Streets Car Lines

(c) Name of employer U R R

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ed Herkenheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carl Herkenheim

(Address) 1825 Clifton av

15 Filed , 19 Robert P. Harrison Registrar

NOV 5 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/13, 1924, to 11/14, 1924,

that I last saw h living on 11/13, 1924,

and that death occurred, on the date stated above, at 1 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis J. Kraft, M. D.

11/15 1924 (Address) 711 Eoplaw av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 17 1924

20 UNDERTAKER Robt E Pentz & Son ADDRESS W. Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92016

D 92016

CERTIFICATE OF DEATH.

REGISTERED NO. 11-6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1620 N. Luzerne ST., 19 WARD)

2-FULL NAME Rebecca Procter

(a) RESIDENCE NO. 1620 N. Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of dead.

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate Old F. Home

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Anne Brown

(Address) Towson Md

15 Filed NOV 15 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12 1924, to Nov. 13 1924,

that I last saw her alive on Nov. 12 1924,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Lagrippe.

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M Hayes M. D.

11/13 1924 (Address) 513 N. Fulton Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cet — DATE OF BURIAL Nov 15 1924

20 UNDERTAKER S. N. Brandt & Son — ADDRESS Balto. Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 15 1924

Cor.—1-12-23—M&T—100 Bks.

D 92017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) E. Eldmore Court St. (Ward)

2-FULL NAME Leslie Brooks

(a) RESIDENCE No. S.S Ellenor St., Ward West Indies

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work writer 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer S.S Ellenor

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Police Dept
(Address) Eastern Dist

15 Filed ..., 192... Robert B. Garfield, Registrar

NOV 15 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severing of Left Jugular Vein, Carotid Artery & Trachea (duration) ... yrs. mos. 6 Hrs

CONTRIBUTORY (Secondary) Murder (duration) ... yrs. ... mos. ... ds

(Signed) James M Fenlon, M. D. (Coroner)

Nov 12 1924 (Address) 702 Cherry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion et	Nov 15 1924
20 UNDERTAKER	ADDRESS
A. W. Brown & Son	Vest & Monta

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 92018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92018

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH
City of BALTIMORE: (No. Mt Hope Retreat St., 28 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Fisher

(a) Residence No. Mt Hope Retreat St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6-DATE OF BIRTH (month, day and year) Sept 7 1853 unknown

7-AGE. 71 yrs. unknown mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown.

PARENTS.

10-NAME OF FATHER, Michael Lynch.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Crondorff.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna.

14- (Informant) Mt Hope Retreat
(Address) Mt Hope

15- NOV 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Nov 14, 1924, that I last saw h[illegible] alive on Nov 14, 1924, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? Chemical.

(Signed) Milton P. Hill, M. D.
, 19 (Address) Wyliesburg Charlestown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dorsey Run — DATE OF BURIAL. Nov 17, 1924

20-UNDERTAKER. Edw. Leavell — ADDRESS 502 E Fayette

NOV 15 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 92019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92019

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5209 York Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Phillips Warren

(a) RESIDENCE. No. 5209 York Road ST., WARD. Cambridge, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	15	

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Cambridge
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Warren

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Blanche Phillips

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Robert Warren
(Address) 5209 York Road

15 Filed ... 19 ... Robert F. Harrison, Registrar

NOV 15 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1924, to Nov. 15, 1924; that I last saw her alive on Nov. 14, 1924, and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Haas, M. D.

11-15- 1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Nov 15 1924

20 UNDERTAKER Wm Leavell

ADDRESS Ellicott City

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

(Ruth Allen)

D 92020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital

REGISTERED NO. 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Ruth Allen

(a) RESIDENCE No. 234 Patapsco ST., Westport WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Orville Allen

6 DATE OF BIRTH (month, day, and year) June 1 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER W. Forbes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Coffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Orville Allen (Address) 715 Patapsco Ave W

NOV 15 1924, 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 14 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-12-, 1924, to 11-14-, 1924,

that I last saw her alive on 11-14-, 1924

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Thrombi?

Gangrenous Ovary

General Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-13-24

Was there an autopsy? operation findings

What test confirmed diagnosis?

(Signed) N. D. Penn, M. D.

11/14/1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampton Va

DATE OF BURIAL Nov 15 1924

20 UNDERTAKER John J. Fields

ADDRESS 1200 W Lombard

mation should be properly classified. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be understood, is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92021

CERTIFICATE OF DEATH.

1113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 W. Lombard ST., 4 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Hartman,

(a) RESIDENCE No. 715 W. Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, (ffl)

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles H. Hartman,

11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Butnoff.

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md
(State or country)

14 Informant Charles H. Hartman,
(Address) 715 W. Lombard St.

15 DEC 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1924 to Nov. 14, 1924, that I last saw him alive on Nov. 14, 1924, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia,

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Acute Ind. - Cirrhosis.

(duration) — yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination.

(Signed) J. Thos. Horton, M. D.

11/14/1924 (Address) 8886 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Nov 18th 1924

20 UNDERTAKER John J. Reddo — ADDRESS 1500 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite statement of cause of death is useless. ATTENTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1761/4 D 92022

CERTIFICATE OF DEATH.

100-001

D 92022

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Smallwood

(a) RESIDENCE NO. St Vincents Orph. ST., WARD H. L. IV. IV

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Parents (Address) Johns Hopkins Hosp.

15 Filed NOV 16 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 8 —, 1924, to Nov 15 —, 1924, that I last saw him alive on Nov 15, 1924, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Anaemia, secondary (food?)

(duration) yrs. 6 mos? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? St. Vincents Infant Asylum

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Kerper, M. D.

11/15, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md — DATE OF BURIAL Nov 17 1924

20 UNDERTAKER Edward H Fisher — ADDRESS Laurel Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

175198 D 92023 — CERTIFICATE OF DEATH. — X 31 D 92023

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

2-FULL NAME Henry Bullock

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

Bristol, Tennessee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bristol Tennessee
(State or country)

PARENTS

10 NAME OF FATHER A. S. Bullock

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Navarro

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records

15 NOV 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1924, to Nov. 15, 1924, that I last saw him alive on Nov 15, 1924, and that death occurred, on the date stated above, at 11²⁰ A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of seminal tract

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Generalized miliary Tuberculosis

(duration) ..... yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Bristol, Tenn.

Did an operation precede death? Yes Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene B. Shaw, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bristol Tenn	11/18 1924
20 UNDERTAKER	ADDRESS
Joseph Ahern	221 Berg

CAUSE OF DEATH in plain words. Statement may be signed by physician only. Certificate may be signed by undertaker only when no physician is in attendance. Property Classification, Street Number or Location of Residence, and Length of Residence are required for completion of certificates.
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 66 D 92024

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2420 E. Chase St ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fluvie Carpentier

(a) RESIDENCE NO U.S. Soldiers Home Wash, D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) 1870 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.Army
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Consult Veteran'S Bureau (Address)

15 Filed ... 192 ... Registrar

THIS is very important

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

(Signed) J. S. Cook, M. D. (Coroner.)

11/15/24. 192 (Address) 508 E .Nirth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leeds Mass	Nov 16 192
20 UNDERTAKER	ADDRESS
Harry H. Weitzke	1031 W. Lombard St

Cor.—1-12-23—M&T—100 Bks.

D 92025 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

90 D 92025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 628 Pine alley ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Salsone

(a) RESIDENCE NO 628 Pine alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Annie Franklin
(Address) 628 Pine alley

15 Filed NOV 6 1924, 192 Burial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W R Gouchenour, M. D. (Coroner.)

11-14, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem

DATE OF BURIAL 11-16 192 4

20 UNDERTAKER Wm Easton

ADDRESS 916 Pine

Rec—12-23-21—E.B.R.S.—400 Bks.

D 92026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92026

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 932 N. Stricker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rodger Greenfield

(a) Residence No. 932 N. Stricker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed or Divorced (write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Martha Greenfield

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) M.E. Church

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Dan'l Simms

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER. Mary Simms

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14-Informant Martha Greenfield

(Address) 932 N. Stricker St.

15-Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/17/24

17-I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1924 to Nov. 12, 1924 that I last saw him alive on Nov. 12, 1924 and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) ✓

(Duration) ✓ yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. R. Natchett M. D

11/13, 1924 (Address) 1715 Druid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. 11-16-, 1924

20-UNDERTAKER. Emil E. Erlon ADDRESS 916 Park ave

In filling out this blank, follow instructions on back of certificate.

Cor.—1-12-21—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92027

CERTIFICATE OF DEATH.

90 D 92027

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Apartments ST. M 3 WARD)

2-FULL NAME Esther Bellis Van Gundy

(a) RESIDENCE NO University Apartments, ST., M 3 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles P. Van Gundy

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D. C.

PARENTS

10 NAME OF FATHER Rodger Bellis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Rebecca Lankford

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Charles P. Van Gundy
(Address) University Parkway, M 3

15 Filed NOV 16 1924 192 Robert R. Brauer, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Appearance of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) ... M. D.
(Coroner.)

11-12, 192 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Balto. D. C.

DATE OF BURIAL Nov 17 1924

20 UNDERTAKER Joseph L. B. Cook

ADDRESS 1003 N. Eutaw St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92028

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1636 W. Baltimore St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Slattery

(a) Residence No. 1636 W. Baltimore St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: John J. Slattery

6-DATE OF BIRTH (month, day and year): Sept. 17, 1854

7-AGE. 70 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Joseph Fry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), West Virginia

12-MAIDEN NAME OF MOTHER, Esther C. Shryock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14-(Informant) William W. Kirwan

(Address) 1636 W. Baltimore Street

NOV 16 1924

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 28, 1924, to Nov 14, 1924, that I last saw h. alive on Nov 12, 1924, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 9 yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

11-14 1924 (Address) 101 N. Carey Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Nov. 17, 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1903 N. Gilmor

Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

BERMAN

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92029

CERTIFICATE OF DEATH.

84 D 92029

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4108 Ridgewood Ave., St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Berman

(a) Residence No. 4108 Ridgewood Ave., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Berman

6-DATE OF BIRTH (month, day and year): Nov. 11th, 1870

7-AGE. 54 yrs. mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer): & Bondsman

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Berman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant): J. Lewis

(Address): 1499 E. Balto. St.

NOV 16 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov, 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan - 1 - 19 15 to Nov - 15 19 24

that I last saw him alive on Nov - 15 19 24

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

1 year (Duration) 9 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

Nephritis (Duration) [illegible]

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr Francis M. D.

11/16, 1924 (Address) 122 E Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Rd. | DATE OF BURIAL, 11-16-, 1924

20-UNDERTAKER, Jas T Lewis | ADDRESS 1499 E. Balto

instructions on back of certificates.

U.S. ARMY

Spec—12-23-21—E.B R.S.—400 Bks.

Gindice

D 92030

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 92030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 943 Eutaw St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rose M. Gindele

(a) Residence No. 943 Eutaw St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Dec. 28, 1908

7-AGE. 15 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School

(b) General nature of industry, business, or establishment in which employed (or employer). Girl

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Lower Falls Md.

PARENTS

10-NAME OF FATHER. Raphael Gindele

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Concetta Canto

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14- Walter Louis V. Gindele (Informant)

(Address) 943 Eutaw St.

NOV 16 1924 ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 th, 1924 to Nov 13 th, 1924

that I last saw her alive on Nov 12 th, 1924

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute Dilatation Serial Murmurs

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. McCatherin M. D.

Nov 14th, 1924 (Address) 1114 Hartford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 17, 1924
20-UNDERTAKER	**ADDRESS**
E. W. Conklin	924 E Eager St

Instructions on back of certificates.

Stoc—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92031 — CERTIFICATE OF DEATH. — 113 — D 92031 — Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 Poultney St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn V. Tennison

(a) Residence No. 27 Poultney St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the Word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 11th 1924

7-AGE. yrs. 4 mos. 4 ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John D. Tennison

11-BIRTHPLACE OF FATHER (city or town) (State or Country), St Mary's Co

12-MAIDEN NAME OF MOTHER, Minnie B. Walker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Somerset Co

11- (Informant) John D. Tennison

(Address) 27 Poultney St

NOV 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 15, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1924 to Nov 15 1924.

that I last saw h[illegible] alive on Nov 15 1924.

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia,

(Duration) 1 wk. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism, (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Hare M. D

19 (Address) 1215 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem — DATE OF BURIAL. Nov 17th 19 24

20-UNDERTAKER. E Schlosnagle Son — ADDRESS 1039 Hanover St

Exact statements of occupations are necessary. Causes of death must be stated in plain terms, so that it may be properly classified. Entries must be made in black ink. Follow instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92032

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1143 Ridgely St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred S. Berry

(a) Residence No. 1143 Ridgely St., Ward.....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): May 26 1905

7-AGE: 19 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Folder

(b) General nature of industry, business, or establishment in which employed (or employer): Book Binding

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: William Berry

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Mary Hartman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-

(Informant): Mary Berry

(Address): 1143 Ridgely St

15-

NOV 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 14th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1924 to Nov. 14 1924

that I last saw h[illegible] alive on Nov. 13 1924,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Wade E. Grampland M. D

, 19 (Address) 913 Poplar Grove St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

DATE OF BURIAL, Nov. 17th, 1924

20-UNDERTAKER: E. Schlosser & Son

ADDRESS 1024 Pennsylvania

Exact Statement of Cause of Death required. Use plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92033

CERTIFICATE OF DEATH.

31 . D 92033

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 329 S Castle St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert Wasielewski

(a) Residence No. 329 S Castle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Cecilia Wasielewski

6-DATE OF BIRTH (month, day and year) Sept. 11-1890

7-AGE. 34 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Henry Wasielewski

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Teofila Kuczynski

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland.

14- (Informant) Cecilia Wasielewska

(Address) 329 S Castle St

NOV 16 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 14 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1924 to Nov 14 1924

that I last saw h[illegible] alive on Nov 14 1924

and that death occurred, on the date stated above, at 2.15 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)

(Duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) carbuncle

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

11/15 1924 (Signed) Joseph L. Vichnikoff M. D.
(Address) 14 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus

DATE OF BURIAL, Nov. 17 1924

UNDERTAKER William Fiszpowski

ADDRESS 618 Eastern Ave.

Exact statement of ... should be carefully supplied. ... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

92034

HEALTH DEPARTMENT—CITY OF BALTIMORE

302 D 92034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Died Enroute to St. Joseph Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Mazenski

(a) RESIDENCE NO 1610 Gough St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? 14 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Consolidated
(c) Name of employer: Gas & Electric Co.

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Peter Mazenski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Polandn

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Marcin Kolb
(Address): 227 S. Ghaple

NOV 16 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Crushed by falling gas pipe.

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Doerr (Coroner.), M. D.

11/15/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 17 1924
20 UNDERTAKER: William Fiaskowski	ADDRESS: 1618 Eastern Ave

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92035

CERTIFICATE OF DEATH.

24-001

D 92035

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 W. Overlea Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Boehmer

(a) RESIDENCE NO 309 W. Overlea Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Boehmer

6 DATE OF BIRTH (month, day, and year) July 27/1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jos. Geo. Trebes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eleanor Fiedler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant F.W.Boehmer
(Address) 309 Overlea Ave

15 Filed NOV 16 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

TION is very important. See that

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Carter, M. D.
(Coroner.)

11/14/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 17 192 24

20 UNDERTAKER C. W. Dill — ADDRESS 3109 Fredk. Ave

Spec.—1-10-21—M&T—1500 Bks.

D 92036

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 92036

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Peterbursky # 1

(a) RESIDENCE NO. 220 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov - 14 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Israel Peterbursky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Friedman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant

(Address) Johns Hopkins Hosp

15 Filed NOV 18 1924 16 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 14 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov - 14, 1924, to Nov - 14, 1924.

that I last saw h... alive on Nov - 14, 1924,

and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles H. Peckham, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Henig Rem — DATE OF BURIAL 11/16 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1137 E Balto st

CAUSE OF DEATH in plain terms, so that ... on back of certificates. ... TION is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

D 92037

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 92037

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

2-FULL NAME Baby Peterbursky # 2

(a) RESIDENCE NO. 220 N. Exeter ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. Life ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov - 14 - 24

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or ..... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Israel Peterbursky

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Friedman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Charles H. Peckham M.D.
(Address) Johns Hopkins Hosp.

15 Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov - 14, 19 24, to Nov - 14, 19 24, that I last saw h alive on Nov - 14, 19 24, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Charles H. Peckham, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hemingway

DATE OF BURIAL 11/16 1924

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that any person may understand it. Do not use abbreviations or technical terms. Be sure to answer all questions. Use ink. Write plainly. Do not write on back of certificates. TION is very important. See instructions on back.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92038

D 92038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 253 Prospect Ave. (St.,) (Ward)

2-FULL NAME Annie E. Schaefer

(a) RESIDENCE NO. 253 Prospect Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schaefer

6 DATE OF BIRTH (month, day, and year) July 13-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mahlon Debow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eleanor Waterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Roland C. Schaefer

(Address) 255 Prospect Ave.

15 Filed NOV 16 1924 Robert R. Krauter, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13-1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Nov 13, 1924, that I last saw her alive on Nov 13, 1924, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorus (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No X Ray

What test confirmed diagnosis?

(Signed) L. N. Wantz, M. D.

Nov 15 1924 (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Nov. 17 1924

20 UNDERTAKER Horace F. Burgee — ADDRESS 363 Fallsway

CAUSE OF DEATH to be plain terms, ... TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 92039

HEALTH DEPARTMENT—CITY OF BALTIMORE

52 D 92039

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 2911 Bernard ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Barnes

(a) RESIDENCE NO. 2911 Bernard St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	49	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dresser

(b) General nature of industry, business, or establishment in which employed (or employer) Spirit Factory

(c) Name of employer Howard, Leo

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Samuel P. Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Theodore A. Dist
(Address) 2911 Bernard St.

15 Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1924, to Nov 15, 1924.

that I last saw her alive on Nov 15 1924

and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Uremia (duration) — yrs. 11 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Rockwood M. D.

(Address) 1000 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL Nov. 17 1924

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Hollins Road

CAUSE OF DEATH to plain letters. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks. ELIZABETH WAGNER

D 92040

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92040

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 945 N. Washington St

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wagner

(a) RESIDENCE NO. 945 N. Washington St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Wagner

6 DATE OF BIRTH (month, day, and year) Jun 3 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22.	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework in Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Kaein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Handloser

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Baltimore Md

14 Informant Edward Wagner

(Address) 945 N Washington St

Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to November 13, 1924, that I last saw h[illegible] alive on November 12, 1924, and that death occurred, on the date stated above, at 10½ a m.

The CAUSE OF DEATH* was as follows:

Toxemia Dis. Of Heart

(Initial Registration)

..... (duration) one yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Dropsy

..... (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas E Norman, M. D.

Nov 15, 1924 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Nov 17 1924

20 UNDERTAKER Wendell Dafferden ADDRESS 372 Lanvale

CAUSE OF DEATH to be filled in plainly, and TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92041

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Report Dulaney st ST., 16 WARD)

2-FULL NAME Mrs Annie M Ewing

(a) RESIDENCE NO. 2817 Harlem ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. E. Ewing

6 DATE OF BIRTH (month, day, and year) Nov 21 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Henry B. Plowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Lottie Slade

13 BIRTHPLACE OF MOTHER (city) (State or country) Baltimore Co Md

14 Informant Geo. E. Ewing

(Address) 2817 Harlem ave

NOV 16 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14th 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/9, 1924, to 11/14, 1924,

that I last saw h alive on 11/14, 1924,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Myocarditis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clement R. Mercer, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 11/17/24

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmonds ave

CAUSE OF DEATH to plainly written, typewritten or printed. Information is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92042

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 92042

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2010 E. Eager St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Novak Jr

(a) Residence No. 2010 E. Eager St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): Nov 14-24

7-AGE: 0 yrs. 0 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Charles J. Novak

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Carrie Armadrill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14-

(Informant) Charles J. Novak Sr

(Address) 2010 E. Eager St.

15-

Filed 1924 192 ROBERT R. KRAUTER, Registrar.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 19 24 to Nov. 15 19 24

that I last saw him alive on Nov. 15 19 24

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edward J. Novak M. D

, 19 (Address) 20 E. Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — DATE OF BURIAL: 11/16 1924

20-UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans St

Spec. 6-2-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92043

CERTIFICATE OF DEATH.

90

D 92043

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 Linden Ave ST. 14 WARD)

2-FULL NAME Morris Levy

(a) RESIDENCE. No. 1936 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-30-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 2/3

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Solomon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Hirsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mabel V. Levy
(Address) 1936 Linden Ave

Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11th, 1924, to Nov. 15, 1924, that I last saw him alive on Nov. 15th, 1924, and that death occurred, on the date stated above, at 4.10 A. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis Arterial

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. W. Kerr M. D.

11/15/1924 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chev. Sholam	11/16 24
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1867 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 92044

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1006 W. Lanvale St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel R. Hogg

(a) Residence No. 1006 W. Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mrs Virginia Hogg

6-DATE OF BIRTH (month, day and year): Feb 25 1855

7-AGE: 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Soap Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Frederick Md

PARENTS:

10-NAME OF FATHER: Samuel R Hogg Sr

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Barbara A Kumbel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa

14-

(Informant): Mrs. Virginia Hogg

(Address): 1006 W Lanvale St

15-

NOV 16 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 15/24

17- I HEREBY CERTIFY, That I attended deceased from June 8 — 1924 to Nov. 15 — 1924

that I last saw him alive on Nov. 15 — 1924

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines, with stenosis of lower bowel

Probably one year or more

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxemia, Uraemia & Coma

about Ten days

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No Effect

Did an operation precede death? Date of June 26/24

Was there an autopsy? No

What test confirmed diagnosis? Histology

(Signed) Carlton M Cook D

Nov. 16 1924 (Address) 2219 St Paul Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md — DATE OF BURIAL: Nov 18, 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E Monument

NAME PLAINLY, WITH ONE AMONG THE GIVEN NAMES IN FULL. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92045

CERTIFICATE OF DEATH.

129 D 92045

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 W Mc Cullough ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar McDaniels

(a) RESIDENCE NO. 15 W Mc Cullough ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha McDaniels

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) DOT

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leesburg Va.

PARENTS

10 NAME OF FATHER Sandy McDaniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucinda Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mrs. N. A. Elliott 1525 Eastlake

15 Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-4 ..., 1924, to 11-14, 1924, that I last saw h[e] alive on 11-14, 1924, and that death occurred, on the date stated above, at 3:15 P. M.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. W. Buckley Butler M. D.

, 19 (Address) 2531 Mc Culloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion	Nov 16 1924
20 UNDERTAKER	ADDRESS
Mrs. N. A. Elliott	1525 Eastlake Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3835 REISTERSTOWN ROAD.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92046

D 92046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 3835 Reisterstown Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Hamburger

(a) RESIDENCE NO. 3835 Reisterstown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? about 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hamburger

6 DATE OF BIRTH (month, day, and year) April 19 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER David Israel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Emil Hamburger

(Address) 3835 Reisterstown Rd.

NOV 16 1924 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular

Because of

Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John J. Morrissey M. D.

(Coroner.)

Nov 15, 1924 (Address) 1632 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	11/16/1924
20 UNDERTAKER	ADDRESS
David Sondheim	115-20 W. Pratt Royal Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92047

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 92047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary 6 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Charlotte Barry

(a) Residence No. Church Home and Infirmary Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) about 1842

7-AGE. 82 yrs. about mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Scotland.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown unknown

14- (Informant) Edward Hayes

(Address) 426 New Hampshire Ave. Wash D C

NOV 16 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1924 to Nov. 14 1924 that I last saw h[illegible] alive on Nov. 14 1924 and that death occurred, on the date stated above, at 11 A.M. The CAUSE OF DEATH* was as follows:

Myocarditis, Arteriosclerosis

Senility, Collapse

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Kirby B. Rice M. D

, 19 (Address) Church Home & Inf

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL, 11-17-24

20-UNDERTAKER. H. C. Myers

ADDRESS 1814 N. Broadway

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92048

CERTIFICATE OF DEATH.

D 92048

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 sixth St., Druid Park WARD)

2-FULL NAME John J Sommer

(a) RESIDENCE NO. 1112 sixth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. PHYSICIANS should state mation should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Sommer

6 DATE OF BIRTH (month, day, and year) Dec 31 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 150

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John J Sommer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Margaret A Bathey

(Address) 112 school st Balto

15 Filed NOV 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1924 to Nov 15, 1924 that I last saw he alive on Nov 15, 1924 and that death occurred, on the date stated above, at 8 P M

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Uremia Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 15, 1924 (Address) 732 Park Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 18 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 92049.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92049

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raynor ave & Lakeland ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dorcas S Forrester.

(a) RESIDENCE No. 1608 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr Charles D Forrester.

6 DATE OF BIRTH (month, day, and year) Jan 21. 1846

7 AGE 78 Years 9 Months 21 Days | If LESS than 1 day, ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Mr John Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Mirabella B Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

14 Informant Mrs McKeel Daughter
(Address) 1211 E Cold 28th St

NOV 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/30, 1924, to 11/15, 1924,

that I last saw h[illegible] alive on 11/15, 1924,

and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.
Chronic Myocarditis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure.

(duration) yrs. mos. 6 Days.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Clement R. Manar, M. D.

, 19 (Address) W B West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Nov 19 1924

20 UNDERTAKER Wm Cook — ADDRESS 5328 Eastern

N. B.—WHITE PAPER, WITH DARK INKS ONLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 10

D 92050

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST. 9 WARD)

2-FULL NAME William Elsworth Duvall

(a) RESIDENCE No Woodbine, Carroll Co, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodbine (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Pearl Crabb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Mother) Mrs Wm. Duvall

(Address) Woodbine, Md.

15 NOV 16 1924

ROBERT R. KRAUTH
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1924, to Nov 15, 1924.

~~that I last saw him alive on~~ ....., 19....,

and that death occurred, on the date stated above, at 12.15 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria
Moribund when admitted to Hospital

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pos. Culture for Diph.

(Signed) Myron G. Tull, M. D.

11/16 1924 Address Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co, Md. Calvary Lutheran Cemetery

DATE OF BURIAL Nov. 16 1924

20 UNDERTAKER C. M. Watts.

ADDRESS Winfield, Md.

N. B.—WHITE PAPER, WITH ORANGE STRIPE, should be used for BIRTH CERTIFICATES. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1924—M&T—1500 Bks.

17603

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 D 92051

CERTIFICATE OF DEATH.

X 10 D 92051

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Maund

(a) RESIDENCE NO. Kingston, Park, Middle River, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Maund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 16 1924 ROBERT R. KRAHLER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1924, to Nov 14, 1924, that I last saw him alive on Nov 14, 1924, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Post diphtheritic paralysis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Throat

(Signed) Chas Jacobson, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 11/16 1924

20 UNDERTAKER J. F. Foley Sons

ADDRESS 1318 Eutaw

N. B.—WHITE PAPER, WITH CARBON SHEET BETWEEN, SHOULD BE USED. INFORMATION should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—F.B.R.S.—400 Blks.

D 92052 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 78

City of BALTIMORE: (No. Mt Hope Retreat St., [illegible] Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ella Good

(a) Residence No. Mt Hope Retreat St., [illegible] Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? 35 yrs. 1 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6-DATE OF BIRTH (month, day and year) Sept. 15. 1889

7-AGE. 35 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). none
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md. Unknown

PARENTS.

10-NAME OF FATHER. John Long.

11-BIRTHPLACH OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ella Bell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Mrs. Hope Jenner
(Address) Mt Hope

15- NOV 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 14. 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Nov. 10, 1924, that I last saw h.. alive on Nov 14, 1924, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Epilepsy

Unknown (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Status Epilepticus

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Hilton Pikes M. D.

, 19 (Address) Highland & Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Cathedral Cemetery — DATE OF BURIAL, Nov 17, 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be given EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92053

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 77 S. Linwood Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank S. Creamer

(a) RESIDENCE NO. 77 S. Linwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Kimberly

6 DATE OF BIRTH (month, day, and year) Mar 19 1880

7 AGE Years 44 Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Maid 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER W. Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hymonis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura Creamer

(Address) 77 S. Linwood ave

15 Filed NOV 16 1924 19 Registrar K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13-24

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1- 1924 to Nov. 13-24

that I last saw him alive on Nov. 13-24,

and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) T.B. Laryngitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick D. Zeman M. D.

(Address) 1913 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakwood Cem

DATE OF BURIAL 11/17 1924

20 UNDERTAKER J. J. Fahey & Son

ADDRESS 1318 E. Fay

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 McCulloh ST. 13 WARD)

2-FULL NAME Emma Ward

(a) RESIDENCE. NO 2313 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Ward.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va Accomac Co.

12 MAIDEN NAME OF MOTHER Susan Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va. Accomac Co.

14 Informant Louisa Burns (Address) 2313 McCulloh St

15 Filed NOV 7 1924 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1924 to Nov 14, 1924 that I last saw her alive on Nov 14, 1924 and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows:

Amyoloid Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) age. Artero Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no Physical Signs.

What test confirmed diagnosis?

(Signed) William H. Finegan M. D.

16, 1924 (Address) 1209 Preston and H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Antum Cmty	11-17 1924
20 UNDERTAKER Helen A. Holland	ADDRESS 1631 Orleans Holland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 92055

HEALTH DEPARTMENT—CITY OF BALTIMORE

Rackemsperger.
161-00

CERTIFICATE OF DEATH.

D 92055
Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. St. Agnes Hospital St., 70 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Rackemsperger.

(a) Residence No. 3838 Monastery Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 Hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 15 1924

7-AGE. yrs. mos. ds. | If LESS than 1 day, 3 hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS

10-NAME OF FATHER. Henry Geo. Rackemsperger

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Maryland.

12-MAIDEN NAME OF MOTHER. Gertrude Helen Monaghan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland.

14-Mrs. Gertrude Rackemsperger
(Informant)
(Address) 3838 Monastery Ave

15-Filed NOV 17 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year). 11/25/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15- 1924 to Nov. 15 1924, that I last saw him alive on Nov. 15- 1924, and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(Breech presentation).
(7½ mos).
(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mother has cardiac decompensation & nephritis. (Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley P. Bonne M. D
11/16, 1924 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. | DATE OF BURIAL: Nov 17, 1924

UNDERTAKER: Joseph B. Cook | ADDRESS: 1003 N. Balto St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92056

100-B 01 92056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2138 Fenwick Ave ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L Knapp

(a) RESIDENCE No 2138 Fenwick Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER George E Knapp

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Emma Schmitt

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs Anna L Knapp
(Address) 2138 Fenwick Ave

15 Filed NOV 17 1924 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924, to Nov 15, 1924

that I last saw him alive on Nov 15, 1924

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E Kuckman M. D.

11/16 1924 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 11/17/24

20 UNDERTAKER George A Farley — ADDRESS Fulton & Lexington

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92057

CERTIFICATE OF DEATH.

31 D 92057

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Harlem Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Jocis

(a) RESIDENCE NO. 1306 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Mrs Anna Gouzis

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE — Years: 58 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer: Joseph & Chas Gouzis

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Frank Gouzis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Jane Lazarich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: Chas. Gouzis

(Address) 122 Sargeant St.

15 Filed NOV 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14- 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Novemb 14, 1924, that I last saw him alive on Nov. 14, 1924, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Anthracosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bronstein, M. D.

11-14 1924 (Address) 3037 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov. 17 1924

20 UNDERTAKER: Chas. L. Fuchsmeier — ADDRESS: 637 Para

mation should be carefully supplied. Also, should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Infant Novak.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92058

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

7 161-001

Registered No. D 92058

City of BALTIMORE: (No. 2010 E. Eager St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Novak

(a) Residence No. 2010 Eager St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced— HUSBAND of, (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 14-24

7-AGE. 0 yrs. 0 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles J. Novak

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Carrie Hromadnik

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Charles J. Novak

(Address) 2010 E. Eager St.

15- NOV 17 1924 ROBERT R. MAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 16 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1924 to Nov 16 1924

that I last saw h[illegible] alive on Nov 16 1924

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Edward Novak M. D

19 (Address) 26 E. Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	11/17, 1924
20-UNDERTAKER, Philip Henry	ADDRESS 306 Orleans St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 92059

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Eastern Avenue ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Heiman

(a) RESIDENCE NO. 1415 Eastern Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 3rd, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md
(State or country)

PARENTS

10 NAME OF FATHER Jacob Heiman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bettie Neusbaum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14
Informant J. Lewis
(Address) 1439 E. Balto. St.,

15
Filed NOV 17 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Alcoholism

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) G. C. Brades, M. D.
(Coroner.)

Nov 17 192 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rebecca Fendall's Cem

DATE OF BURIAL: 11 17 1924

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

CAUSE OF DEATH to be plainly written. Exact statement of occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92060

CERTIFICATE OF DEATH.

D 92060

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 S. Sixth St. Brooklyn 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. P. Meyers

(a) Residence No. 109 S. Sixth St. Brooklyn St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa C. Meyers

6-DATE OF BIRTH (month, day and year) Nov. 2, 1851

7-AGE. 73 yrs. mos. 12 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Machinist

(b) General nature of industry, business, or establishment in which employed (or employer). B. & O.R. R.

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Frederick Meyers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Newman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Talbot Co., Md.

14- (Informant) Mrs. Louisa C. Meyers

(Address) 109 S. Sixth St. Brooklyn

15- Filed NOV 17 1924 ROBERT P. KRAUTER Registrar. Chief Deputy Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1/24, 19.. to Nov 14/24 that I last saw him alive on Nov 14/24, 19.., and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Primal Kimberly (Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Kolb M. D.

(Address) 1103 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet

DATE OF BURIAL. Nov 17, 1924

20-UNDERTAKER John F Denny

ADDRESS 415 Light St

Exact statement of OCCUPATION is very important. See that it may be properly classified. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

92061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92061

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2517 Liberty Heights Ave. ST., 15 WARD) 90

2-FULL NAME Abraham Glass

(a) RESIDENCE NO. 2517 Liberty Heights Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Goods Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 945

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Rev. Herman Glass

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Fried

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Rachel Glass
(Address) 2517 Liberty Heights Ave. DAUTER.

15 Filed ..... 19 ..... Burial Permit Clerk.
Registrar

NOV 17 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16/24 19

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to November 16, 1924.
that I last saw him alive on November 16, 1924.
and that death occurred, on the date stated above, at 2.10 A. m.
The CAUSE OF DEATH* was as follows:

Congenital Heart Disease
Chronic Myocarditis
(duration) 27 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Charles S. Friedman M. D.
, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 11/17/24 19

20 UNDERTAKER David Sondheim

ADDRESS 118-20 20. 2nd. Royal Ave.

mation should be carefully prepared so that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92062 **CERTIFICATE OF DEATH.** 31 D 92062

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Elizabeth's Home St., 9 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Eustace Riechert

(a) Residence No. St. Elizabeth's Home Chemt Heights Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	negro	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 15/24

7-AGE, ...yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Sydney Williams

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country),

12-MAIDEN NAME OF MOTHER, Julia Riechert

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country),

14-
(Informant).....
(Address).....

15-
Filed ..... 19.....
ROBERT R. MASTER, Registrar.

NOV 7 1924

1949

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). November 14/24

17- I HEREBY CERTIFY, That I attended deceased from October 4th, 19 24, to November 13, 19 24, that I last saw him alive on November 13, 19 24, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

.....(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

.....(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Boyd, M. D.

Nov 14, 1924 (Address) 2006 E Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, ... 19.....
20-UNDERTAKER,	ADDRESS

JOHNS HOPKINS HOSPITAL NOV 15 1924

In plain terms, is that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92063

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. D 92063

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Ruth Baker

(a) RESIDENCE NO. 1907 Patterson Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Nov 8/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Roland R. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Helen Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Roland R. Baker (Address) 1907 Patterson Pk Ave

15 Filed NOV 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Watkins, M. D. (Coroner)

11/17/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/17 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford Ave

TION is very important. See that the record of each death is complete and correct.

Spec.—1-10-21—M&T—1500 Bks.

D 92064 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92064

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 307 N Calhoun ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Amelia Sheffer

(a) RESIDENCE No. 307 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 28 1870

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Emerson Drug Co

9 BIRTHPLACE (city or town) Bells Mt.
(State or country)

PARENTS

10 NAME OF FATHER Ebenezer Pumphrey

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Amelia Dickner

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Lillian Sheffer
(Address) 307 N. Calhoun St.

15 Filed NOV 7 1924 Robert R. Kranitz Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924, to Nov 15, 1924, that I last saw her alive on Nov 15, 1924, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy D. McCleary M. D.

(Address) 200 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Nov 18 1924

20 UNDERTAKER Wm Tickner & Sons ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Ruzicka 8009 Cat Pk Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92065

CERTIFICATE OF DEATH.

111-007

D 92065
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 East Biddle St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Dahle

(a) Residence No. 903 East Biddle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE: William F Dahle

6-DATE OF BIRTH (month, day and year): Oct 29, 1875

7-AGE: 19 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: John T Cooper

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Philadelphia Penna

12-MAIDEN NAME OF MOTHER: Katherine Gruner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md.

14-(Informant): William F Dahle
(Address): 903 E. Biddle St

15-Filed NOV 7 1924 192.... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 14 1924

17-I HEREBY CERTIFY, That I attended deceased from 8-1-24 to 11-14-24

That I last saw him alive on 11-13 19 24

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

acute Nephritis
acute Mitral Regurgitation
Pulmonary Thrombosis
(Duration) ....yrs. ....mos.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation
(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Rupp M.D.
(Address) 830 N Duncan

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 15 19 24

20-UNDERTAKER: J. M. Cook — ADDRESS: 502 E Lexington

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92066

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Kennedy ST., 20 WARD)

2-FULL NAME Laura L. McFadden

(a) RESIDENCE NO. 1502 Kennedy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W McFadden

6 DATE OF BIRTH (month, day, and year) Feb 10, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick, Md
(State or country)

PARENTS

10 NAME OF FATHER Philip Lambright

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary McCarthy

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Laura L. Mcfad
(Address) 1502 Kennedy

15 NOV 17 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1924, to Nov 16, 1924, that I last saw h[illegible] alive on Nov 16, 1924, and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred J Smith, M. D.

Nov 16 1924 (Address) 2516 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Nov 19 1924

20 UNDERTAKER Wm Cook — ADDRESS 1312 E Fayette Ave.

Spec—12-23-21—E.B.R.S.—400 Blks.

Buckmann 2002 W Lexington St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92067

CERTIFICATE OF DEATH.

90 D 92067

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 270 N. Holly St. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fisher

(a) Residence No. 270 N. Holly St. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C

6-DATE OF BIRTH (month, day and year) June 5 [illegible]

7-AGE	If LESS than 1 day
69 yrs. ..... mos. ..... ds.	....hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Cooper

(b) General nature of Industry, business, or establishment in which employed (or employer) ..... Self. 0/35

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... Md

(State or Country).

PARENTS.

10-NAME OF FATHER, Wm Fisher

11-BIRTHPLACE OF FATHER (city or town) ..... Md

(State or Country).

12-MAIDEN NAME OF MOTHER, Lucian Crandol.

13-BIRTHPLACE OF MOTHER (city or town) ..... Md

(State or Country).

14- (Informant) Howard Fisher

(Address) 273 N. Holly St.

15- NOV 17 1924 ROBERT R. QUARTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 16 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 to Nov 16 24

that I last saw him alive on Nov 15 24

and that death occurred, on the date stated above, at 7 A M

The CAUSE OF DEATH* was as follows: (Dictation)

Dilatation of Heart

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 8 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hallie E Knickmann M. D

11/16 19 24 (Address) 2002 W. Lex. St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 18 1924
Druid Hill Park	
20-UNDERTAKER, Wm Cook	ADDRESS 502 E. N. Ave

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Blks. JOHN MORRIS

92068

HEALTH DEPARTMENT—CITY OF BALTIMORE

92068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Lemmon St., 18 Ward) Registered No. 31

2-FULL NAME... John Morris

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No.... 921 Lemmon St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 18, 1860

7-AGE. 64 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Millhand

(b) General nature of industry, business, or establishment in which employed (or employer)... 046

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Morris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), U. States

12-MAIDEN NAME OF MOTHER, Mahraun

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) Mrs Laura McDaniel

(Address) 921 Lemmon St

15-

FILED NOV 17 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/14/24

17- I HEREBY CERTIFY, That I attended deceased from 10/10/, 1924, to 11/14/, 1924

that I last saw b— alive on 11/14/24, 19....

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Pul Phthisis

(Duration) one hour yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hist & Dx Bact & Blood

(Signed) Bernard Long, M. D.

11/15/ 1924 (Address) 910 W Lom St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park	Nov 18, 1924

20-UNDERTAKER.	ADDRESS
George J Smith	1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92069

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92069

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 3 Forman Ave St., 20 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Abilhorn Cece

(a) Residence No. 3 Forman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 31 1899

7-AGE. 24 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Helper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country).

PARENTS.

10-NAME OF FATHER, Jacob Abilhorn

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country).

12-MAIDEN NAME OF MOTHER, Anna Rebecca

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country).

14- (Informant) Mrs Elizabeth

(Address) 3 Forman Ave

15- Filed NOV 17 1924 19.. Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 14 1924

17- I HEREBY CERTIFY, That I attended deceased from 11/12, 1924, to 11/14, 1924, that I last saw h.. alive on 11/14/ 1924 and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Cor Pulmonale

(Duration) under yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (Pul.)

(Duration) 2 or 3 (?) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) B. F. Tang, M. D.

11/17, 1924 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, Nov 17, 1924

20-UNDERTAKER George J Smith — ADDRESS 153 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-24—MAT—1500 Blks.

D 92970

17560 Medical

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92070

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Joseph Yammer

(a) RESIDENCE NO. 633 N. Duncan St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the Late Margaret Yammer

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barrel maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Yammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helena Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 17 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1924, to Nov. 15, 1924, that I last saw him alive on Nov. 15, 1924, and that death occurred, on the date stated above, at 12⁵⁵ P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure from chronic cardio vascular renal hypertensive disease with ventricular fibrillation then heart block.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? insidious development at home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Roentgenology, blood chemistry, clinical laboratory

(Signed) Louis E. Martin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Wathen Cemetery

DATE OF BURIAL Nov 19 24

20 UNDERTAKER Wm C. Miller & Son

ADDRESS 2334 Jeffer

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1710 D 92071

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2427 McElderry St ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry B. Senf

(a) RESIDENCE NO 2427 McElderry St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Senf

6 DATE OF BIRTH (month, day, and year) Feb 26/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer) Schmidt Bakery
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Carl Senf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Perkins
(Address) 2427 McElderry St

15 Filed NOV 7 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shots into brain-lft temple

Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Carter, M. D.
(Coroner)

11/15/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	Nov. 18 1924
20 UNDERTAKER	ADDRESS
Wm. L. Miller & Son	2804 Jefferson

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92072

CERTIFICATE OF DEATH.

D 92072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., WARD 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha V. Holland

(a) RESIDENCE NO. 203 N. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Spencer E. Holland

6 DATE OF BIRTH (month, day, and year) Dec 22, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John H. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida A. Spedden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Spencer E. Holland

(Address) 203 N. Linwood Ave

15 Filed NOV 17 1924 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15- 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-15- 1924 to 11-15- 1924

that I last saw her alive on 11-15- 1924

and that death occurred, on the date stated above, at 10 25 a. m.

The CAUSE OF DEATH* was as follows:

Self induced abortion

Septicemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carr, M. D.

(Address) Medical Dept. Hospital. 11/18/1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Nov. 18 1924
20 UNDERTAKER Burkhart & Winkler	ADDRESS 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1046 N. Eden ST., 10 WARD)

2-FULL NAME Mrs. Theresa Bock.

(a) RESIDENCE NO. 1046 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed ~~Divorced~~

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Ruebsaat.

6 DATE OF BIRTH (month, day, and year) April 7, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	71	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Simon Bock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Krimmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Miss Anna Bock

(Address) 1046 N. Eden St.

15 Filed NOV 7 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. ..., 1923, to Nov. 15, ..., 1924, that I last saw her alive on Nov. 14, ..., 1924, and that death occurred, on the date stated above, at 8.05 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No especial test.

(Signed) W. H. Herman, M. D.

(Address) 1012 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 19-1924
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

100 D 92074

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3813 E. Pratt St. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Garofalo

(a) Residence No..... 3813 E. Pratt St. St.,..... Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 28-1923

7-AGE, 1 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore

(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael Garofalo

11-BIRTHPLACE OF FATHER (city or town)..... Italy.

(State or Country),

12-MAIDEN NAME OF MOTHER, Sarcia Zilliano

13-BIRTHPLACE OF MOTHER (city or town)..... Italy

(State or Country),

14- (Informant)..... Michael Garofalo

(Address)..... 3813 E. Pratt St.

15- [illegible] Registrar.

NOV 17 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 19 24 (to Nov. 15 19 24

that I last saw him alive on Nov. 15 19 24

and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Philibert Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Nov. 17th 19 24

20-UNDERTAKER, Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92075

CERTIFICATE OF DEATH.

31

D 92075

1-PLACE OF DEATH

City of BALTIMORE: (No. 1120 S. 1st St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Piotr Sweder

(a) Residence No. 1120 S. 1st St., 26 Ward.....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sep. 20 - 1860

7-AGE. 57 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Wojciech Sweder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Jadwiga Beres

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Victoria Sweder

(Address) 1120 S. 1st

NOV 7 1924

Filed..... 192.....

ROBERT R. CRAWFORD Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov-14-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 1924 to Nov. 14 1924

that I last saw h[illegible] alive on Nov 14 1924

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis (Yes?)

(Duration) 4 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B Brownlee M. D

11-17- 1924 (Address) 3037 Odonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR MEMORIAL.	DATE OF BURIAL.
St Stanislaus Cem	Nov-18, 1924
20-UNDERTAKER.	ADDRESS
Stephen J Fralkowski	1000 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Wisniewski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92076

CERTIFICATE OF DEATH.

90 D 92076

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 S Kenwood Ave. ST., WARD)

2-FULL NAME Frank Wisniewski

(a) RESIDENCE NO. 927 S Kenwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1870 - Mar 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Veronica Wisniewski
(Address) 927 S Kenwood Ave

15 Filed ..... 192 ..... Registrar

NOV 1 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) G. C. Radcliffe, M. D.
(Coroner.)

Nov 16 192 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov 18 1924
20 UNDERTAKER	ADDRESS
Shipley & Trackman	1010 S Kenwood Ave

THIS CERTIFICATE may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Write plain terms, so that it

Spec—12-23-21—E.B.R.S.—400 Eks.

D 92077 HEALTH DEPARTMENT—CITY OF BALTIMORE 45 D 92077

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 506 S. Rose St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Thomas Skibinski

(a) Residence No... 506 S. Rose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.)
Male	white	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Josepha Skibinski.

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 70 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)... Odd
(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS:
10-NAME OF FATHER, ? Skibinski
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mr. Katherine Skibinski
(Address) 506 S. Rose St.

15- NOV 17 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14. 1924 to Nov. 15, 1924. that I last saw h. ~~in~~alive on Nov. 15, 1924. and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S.G.S.

(Signed) John J. Kruger M. D.

. 19 (Address) 2637 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
H. Stanislaus,	Nov. 19, 1924

20-UNDERTAKER.	ADDRESS
M. F. Sadowski	705 S. Ann St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92078

CERTIFICATE OF DEATH.

90 D 92078

1-PLACE OF DEATH ~~Bayview State~~ Hospital

Registered No.....

City of BALTIMORE: (No.....St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O'Brien

(a) Residence No. 808 E. Pratt St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 042

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Indiana

PARENTS.

10-NAME OF FATHER, John O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14- (Informant) Municipal Hospital Records

(Address)

15-

Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/14/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 4, 1924, to Nov 24, 1924, that I last saw him alive on Nov 14, 1924, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis; chronic myocarditis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Claude S. Bruce, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Dove's Heart	11/17, 19....
20-UNDERTAKER,	ADDRESS
P. Fate & Sons	318 Light

Burial Permit Clerk

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-002

D 92079

CERTIFICATE OF DEATH

118 D 92079

1-PLACE OF DEATH Bay View Hospital

Registered No.....

City of BALTIMORE: (No. ..... St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neal, Wm. F.

(a) Residence No. Home (Bay View Hosp St.) Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, Col.

5-WHETHER Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1884

7-AGE 40 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of Industry, business, or establishment in which employed (or employer) ? 040

(c) Name of employer ?

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do Md.

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do.

14-

(Informant) Bay View Hospital

(Address)

15-

Filed ..... 192 ..... Registrar.

NOV 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/14/24.

17- I HEREBY CERTIFY, That I attended deceased from 9/16/1907 to 11/14/1924

that I last saw him alive on 11/14/1924

and that death occurred, on the date stated above, at 10.25 a.m.

The CAUSE OF DEATH* was as follows: acute Intestinal Obstruction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ? generalized Anemia exclusive

(Duration) I yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of Specimens.

(Signed) N. Goldsmith M.D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart	11/17/24 19....
20-UNDERTAKER,	ADDRESS
C. C. Foley & Sons	1318 Light

Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks. (Michael J. Feilley)

D 92080

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals St. [illegible] Ward 26) Registered No. 151

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. J. Feilley

(a) Residence No. Boy Scout Headquarters St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2y. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): 1878

7-AGE: 46 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Andrew Feilley

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14- (Informant): San View Hospital

(Address):

15- Filed NOV 7 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11/4/24

17- I HEREBY CERTIFY, That I attended deceased from 11/10, 1924 to 11/11, 1924

that I last saw h[illegible] alive on 11/11, 1924

and that death occurred, on the date stated above, at 1.48 a. m.

The CAUSE OF DEATH* was as follows:

Ortera sclerosis gangrene of both feet.

(Duration) One year mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Ct —

(Signed) Claude A. Draco M. D.

11-11, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Harmony Cemetery	11/7/24 19....
20-UNDERTAKER.	ADDRESS
J. Fahey & Sons	131 Light St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Women's Hospital

City of BALTIMORE: (No. Lafayette & Johns St. 14 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia C. Ball

(a) Residence No. Buckeystown Md St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, ~~Married~~ Widowed, Widowed or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John L Ball

6-DATE OF BIRTH (month, day and year) Sept 10, 1851

7-AGE, 73 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Buckeystown Md

PARENTS.

10-NAME OF FATHER, ~~Joseph~~ Joseph M. Chiswell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Buckeystown Md

12-MAIDEN NAME OF MOTHER, Eleanor White

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Buckeystown, Md

14- (Informant) Mrs John W Ball

(Address) Buckeystown Md

15- Filed ~~Dec~~ Nov 19 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 17-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924, to Nov 17, 1924, that I last saw h.. alive on Nov 17, 1924, and that death occurred, on the date stated above, at 11 55 a.m.

The CAUSE OF DEATH* was as follows:

Uremia following an acute respiratory infection

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Why not?

What test confirmed diagnosis? History Phys exam Blood chem

(Signed) J. Arthur York, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Frederick Md — DATE OF BURIAL, Nov 20 1924

20-UNDERTAKER, M. R. Etchison & Son — ADDRESS Frederick Md.

1 T 1924

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D 92082 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. Patterson Pk. Ave. ST., WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Bowling.

(a) RESIDENCE No. 512 N. Patterson Pk. Av. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E. Bowling.

6 DATE OF BIRTH (month, day, and year): Mar 10 1860

7 AGE: Years 64 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

63

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John E. Heisner.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mrs. Carrie Heisner.

(Address): 512 N. Patterson Pk Ave

15 Filed NOV 17 1924, 19

Robert F. Haffiden, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15" 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924, to Nov. 15, 1924, that I last saw her alive on Nov. 15, 1924, and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Brooks M. D.

, 19 (Address) 845 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: Nov 18 1924

20 UNDERTAKER: Geo M. Fink & Son

ADDRESS: 811 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2313 E. Madison St. St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Herman B. Goyert

(a) Residence No. 2313 E. Madison St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Mrs. Mary Goyert

6-DATE OF BIRTH (month, day and year) Sept 15, 1861

7-AGE, 63 yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Horseshoer

(b) General nature of industry, business, or establishment in which employed (or employer) ..... yes

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Herman Goyert Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs. Mary Goyert

(Address) 2313 E. Madison St

15- Filed ..... 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). November 15/24

17- I HEREBY CERTIFY, That I attended deceased from November 4, 1924, to November 14, 1924, that I last saw h. alive on November 14, 1924, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of July 1924

Was there an autopsy? No

What test confirmed diagnosis? Laboratory + x-ray

(Signed) Frank J. Ayd, M. D.

Nov 16, 1924 (Address) 200 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Nov 18th, 1924

20-UNDERTAKER, Geo M. Smith & Son ADDRESS 811 N Wolfe

NOV 17 1924

Exact statement of OCCUPATION is very important.

In plain terms, so that it may be properly classified.

See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92084

CERTIFICATE OF DEATH.

101001

D 92084

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nancy Wartham

(a) Residence No. 3358 Strickland Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Wht

5-Single, Married, Widowed, Divorced (write the word)

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs Wartham

6-DATE OF BIRTH (month, day and year) Dec. 17, 1885

7-AGE. 38 yrs. 10 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 140
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Nathan B. Warthen

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-~~MAIDEN~~ NAME OF MOTHER Mary E. Hyatt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Mrs. Nakella A. Warthen
(Address) 3358 Strickland St Balt Md

15- Filed ..... 192.....
Robert P. Harrison,
Registrar.
1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 14, 19 24 to Nov 16, 19 24

that I last saw h.. alive on 11/16 19 24

and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration) yrs. mos. 6 hrs

CONTRIBUTORY (Secondary) Rt. Lobar pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John T Sherman M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Nov. 18, 19 24

20-UNDERTAKER: Easton Sons — ADDRESS: Elliott City

Exact statement of OCCUPATION is very important. See ... in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92085

CERTIFICATE OF DEATH.

1901

122 D 92085

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Mills.

(a) RESIDENCE NO 1611 First St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ the late Catherine Mills

6 DATE OF BIRTH (month, day, and year) July 31, 1863

7 AGE: Years 61, Months 3, Days 14. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pottery Hand
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER Frederick Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Edward Mills
(Address): Irvington A. A. Co

15 Filed ..., 192 ... Registrar

Burial Permit Clerk.

V 7 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows

Cirrhosis Liver

(Duration) yrs. mos. 2wks

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

(Signed) G C Yates, M. D.
(Coroner.)

Nov 17 192 (Address) 1536 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. — DATE OF BURIAL: Nov. 18, 1924

20 UNDERTAKER: A. Howard Evans — ADDRESS: 38 E. Fort Ave.

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3788 Monastery Ave. St., 90 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry G. Mahlmann

(a) Residence No. 3788 Monastery Ave. St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 30 1872

7-AGE, 52 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer: .....

9-BIRTHPLACE (city or town), (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: Herman H. Mahlmann

11-BIRTHPLACE OF FATHER (city or town), (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dorette Kaufmann

13-BIRTHPLACE OF MOTHER (city or town), (State or Country): Germany

14- (Informant): Miss Herminia Mahlmann
(Address): 3788 Monastery Ave.

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

V 17 1924

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 19 24 to Nov 16 19 24
that I last saw him alive on Nov. 16 19 24
and that death occurred, on the date stated above, at 10.20 A. m.
The CAUSE OF DEATH* was as follows:

Thyroidectomy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mountain

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 1-24

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Emory H. Penn M. D.

11/17 19 24 (Address) 225 W. Monument Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Nov 18 1924
20-UNDERTAKER. Joseph L. B. Cook	ADDRESS 1003 N. Bal

If the physician cannot state the CAUSE OF DEATH so that it may be properly classified, Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92087

CERTIFICATE OF DEATH.

45 D 92087

1-PLACE OF DEATH Lunacy Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Davis Garthright

(a) RESIDENCE No. 1042 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Garthright

6 DATE OF BIRTH (month, day, and year) Aug. 3 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63.	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) (Self) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John W Garthright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy A Ballou

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant C. D. Garthright (Address) Kinston, N. C

15 FILED Nov 1, 1924 Robert [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/27, 1924, to 11/16, 1924, that I last saw him alive on 11/16, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Colloid carcinoma of colon.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 4/3/24

Was there an autopsy?

What test confirmed diagnosis? operation

(Signed) M Edwards, M. D.

11-18 24 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Nov 18, 1924

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Gilt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 92088 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92088

10f-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Kuper Place ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Stonesifer

(a) RESIDENCE No. 1403 Kuper Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Stonesifer

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover, Penna.

PARENTS

10 NAME OF FATHER Evicus Stonesifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover, Pa.

12 MAIDEN NAME OF MOTHER Emma Bugle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover, Pa.

14 Informant Caroline Stonesifer

(Address) 1403 Kuper Place

15 Filed 1924, 19 Robert P. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 19 24, to Nov 14, 19 24,

that I last saw him alive on Nov. 14, 1924, 19,

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw V. Coolahan, M. D.

11-15-1924 (Address) 24 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	11-18-1924
20 UNDERTAKER	ADDRESS
Robt. Brookes & Son	Calhoun & Hollins sts

TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92089

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 N. Carolina ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hoffman.

(a) RESIDENCE. No. 1716 N Carolina ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. Hoffman

6 DATE OF BIRTH (month, day, and year) Oct 15/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hazleton Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) S. Luster Hoffman 1716 Carolina St.

15 Filed ....., 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to Nov 15, 1924, that I last saw her alive on Nov 14, 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Donaldson, M. D.

, 19 (Address) 1714 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartleton, Pa.

DATE OF BURIAL 11/18/24

20 UNDERTAKER George D. Ruth Drug

ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificates. ...at it may be properly classified. Exact statement of OC... plain terms, so that it ...

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3137 Cedar ave St. 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Sauerwald

(a) Residence No. 3137 Cedar ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lula Sauerwald

6-DATE OF BIRTH (month, day and year) Sept 26 1881

7-AGE. 43 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Sub Station Mgr

(b) General nature of industry, business, or establishment in which employed (or employer)..... Balto News

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm Sauerwald

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Sarah Loch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Edw L Sauerwald

(Address) 334 N Fulton ave

15- Filed 1924 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 16/24

17- I HEREBY CERTIFY, That I attended deceased from April 5 1924 to March 16 1924

that I last saw h[illegible] alive on March 16 1924

and that death occurred, on the date stated above, at 12-30 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Chandler M D

March 16 1924 (Address) 1504 McCulloh

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. March 19 1924

20-UNDERTAKER. Temple Farley Fulton & Smythe

ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92091 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Fox

(a) RESIDENCE NO. Stevensville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	7	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Stevensville, Md.,

10 NAME OF FATHER John W. Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent County, Md.,

12 MAIDEN NAME OF MOTHER Catherine Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stevensville Md.

14 Informant Mrs. Catherine Fox (Address) Stevensville Md. Rt. 1

15 Filed NOV 17 1924, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept - 5, 1924, to Nov. 16, 1924, that I last saw her alive on Nov. 16, 1924, and that death occurred, on the date stated above, at 1:45 a m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chr)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Jno A Thompson M. D.

, 19 (Address) Md Ave Stevensville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stevensville, Md Lawn Cemetery Co

DATE OF BURIAL Nov 18 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Pratt

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Carlton Terrace ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Bishop

(a) RESIDENCE NO 2743 Winchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Penna
(State or country)

PARENTS

10 NAME OF FATHER John Bishop

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Rollman

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Carrie Bishop
(Address) 2743 Winchester

15 Filed JUL 1 1924, 192 Bert L. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner)

June 17, 1924 (Address) 1137 Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakin Park	June 18 1924
20 UNDERTAKER	ADDRESS
Martin Kirby	1822 W. Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Blks.

176259
D 92093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-001 D 92093

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bolden

(a) RESIDENCE NO. 1336 N. Gilmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child yrs
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Bolden

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Tilman

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 18 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Nov 15, 1924, that I last saw h.. alive on Nov 15, 1924, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes over Date of 11/14/24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kerper, M. D.

11/16, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 18, 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Hennd Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Henry Goldys

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92094

CERTIFICATE OF DEATH.

9100 D 92094

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1603 Shakespeare St., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Goldys.

(a) RESIDENCE No. 1603 Shakespeare ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sophia Goldys

6 DATE OF BIRTH (month, day, and year) Dec 13 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr John Goldys son
(Address) 1602 Shakespeare

15 Filed ..... 192 ..... Registrar

BZC 8 1AON • ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

192 (Address) 1403 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Nov	18 192 4
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92095

D 92095

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3721 Jamanda ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Stutman

(a) Residence No. 3721 Jamanda ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ida Stutman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 83 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER Meyer Stutman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER Goldie Rotman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) S. Stutman or Sam Stutman

(Address) 3721 Jamanda Ave.

15- Filed NOV 18 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 17th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1924 to Nov. 17 1924

that I last saw him alive on Nov. 17 1924

and that death occurred, on the date stated above, at 10 15 P M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) B. Kadner M. D.

19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wetheren Woodlawn

DATE OF BURIAL. 11/18, 19 24

20-UNDERTAKER. Jack Levis

ADDRESS 1439 E Balt St

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92096 HEALTH DEPARTMENT—CITY OF BALTIMORE

117 D 92096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Payson ave & Dukeland ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Louis Yarnofsky

(a) RESIDENCE No. 505 S Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Sophie Yarnofsky.

6 DATE OF BIRTH (month, day, and year) May 15, 1889

7 AGE 35 Years 6 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor. 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Joseph Molotsky.

9 BIRTHPLACE (city or town) (State or country) Patrabintt. Russia

PARENTS

10 NAME OF FATHER Mr Jacab Yarnofsky.

11 BIRTHPLACE OF FATHER (city or town) Unknown. (State or country) Russia.

12 MAIDEN NAME OF MOTHER Mrs Mindle Shungast

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Russia

14 Informant Mr E. A. Weinstein Baltimore Md (Address) 505 S Pulaski St

15 Filed NOV 18 1924 ROBERT R. WALTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/14, 1924, to 11/18, 1924, that I last saw him alive on 11/18, 1924, and that death occurred, on the date stated above, at 2:06 A m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Streptococcic Septicemia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 11/14/24 + 11/15/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operation

(Signed) Clement B. Monrad, M. D.

11/18, 1924 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrersburgh Pa DATE OF BURIAL 11/19 1924

20 UNDERTAKER Jack Lewis 1409 E Balt ADDRESS

N. B.—WRITE PLAINLY, WITH USE OF BLACK INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92097

CERTIFICATE OF DEATH.

90 D 92097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 S. Hanselberger St., 23 WARD)

2-FULL NAME Grace Tilley (or Tully)

(a) RESIDENCE NO 1118 Hanselbergers. Ct WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harvey Tilley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21	years			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Frank Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Dawson Torrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mandy Brandy (Address) 212 N. Hamburg

15 Filed NOV 18 1924, 192 ROBERT R. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) prob. Valv. Dis. Heart

(duration) 1 yrs. 1 mos. ds.

(Signed) W. T. Ruley, M. D.

Nov. 17, 1924 (Address) 1639 Lang (Coroner.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — DATE OF BURIAL Nov 20 1924

20 UNDERTAKER W. R. Brown & Son — ADDRESS 1081 N. Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92098

CERTIFICATE OF DEATH.

101-001

D 92098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 W. Hamburg ST. 23 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lulu Owens

(a) RESIDENCE. No. 1536 W. Hamburg ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Owens

6 DATE OF BIRTH (month, day, and year) June 18-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waste Md

10 NAME OF FATHER Washington Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara Party

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William H Owens

(Address) 1534 Hamburg St

15 Filed NOV 18 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924, to Nov 15, 1924, that I last saw h[illegible] alive on Nov 14, 1924, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Ca Pneum

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical findings & Symptoms

(Signed) C. H. Miller M. D.

Nov 17 1924 (Address) 7125 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov 18 1924
20 UNDERTAKER	**ADDRESS**
C. L. Bramble Son	1017 N Mary

...ATE should be stated EXACTLY. PHYSICIANS should state ...at it may be properly classified. Exact statement of OCCUPA... ...See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Univ. Hospital

REGISTERED NO. 109-09

CITY OF BALTIMORE: (No. Lombard & Green ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. McNally

(a) RESIDENCE NO. 305 Allegheny ave ST., Towson WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie

6 DATE OF BIRTH (month, day, and year) Oct 16th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry R. McNally

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Justina Jarrett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto City

14 Informant Henry R. McNally
(Address) 305 Allegheny ave

15 Filed NOV 18 1924, 19.. ROGER M. [illegible] JR., Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Nov. 16, 1924,

that I last saw h~~im~~ alive on Nov. 16, 1924,

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Streptococci Infection Throat

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov. 16/24 Tracheotomy

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Bs. Whaley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Nov 19 1924
20 UNDERTAKER	ADDRESS
Lobar Burns Sons	Towson.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. AFE

DAK

Spec.—1-10-21—M&T—1500 Bks.

17692 6

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92100

CERTIFICATE OF DEATH.

57 D 92100

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Louis Broll

(a) RESIDENCE No. 841 S Montford Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): ? Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Riesde

(Address): JOHNS HOPKINS HOSPITAL

15 Filed NOV 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 - , 1924, to Nov 15 - , 1924, that I last saw him alive on Nov 15 - , 1924, and that death occurred, on the date stated above, at 12 M. P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Arteriosclerotic bulbar palsy,

Diabetes Mellitus (duration) 2 yrs. — mos. — da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Louis E. Mattern, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cemetery	Nov 18 1924
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92101

CERTIFICATE OF DEATH.

74-001

D 92101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph Walters

(a) RESIDENCE NO. 2912 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12. 1849

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	75	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Young & Company.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Walter

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)

14 Informant Mr. Walter L. Batty
(Address) 2122 Orleans St.

15 Filed NOV 18 1924 FOREST R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Nov. 15, 1924, that I last saw h[illegible] alive on Nov. 15, 1924, and that death occurred, on the date stated above, at 1245 P m.

The CAUSE OF DEATH* was as follows:

Hypertension; Chr. Myocarditis; Chr. Nephritis; Arteriosclerosis general, Cardiac Hypertrophy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL Nov. 18 1924

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Fleet

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92102

CERTIFICATE OF DEATH.

118-001

D 92102

1-PLACE OF DEATH St. Joseph's Hospital 1

City of BALTIMORE (No. ... St., ... Ward) Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Eversmeier

(a) Residence No. 20 S. East Ave St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 4. 1870

7-AGE. 53 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boxmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Canton Box Co.

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS:

10-NAME OF FATHER, Frederick Eversmeier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mina Buttermeier

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs. Mary Lampna

(Address) 20 S. Bath Ave

15-

Filed NOV 18 1924 ROBERT R. MAGUIRE, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1924 to Nov 17 1924

that I last saw him alive on Nov. 17 1924

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Pulmonary Embolism

(Duration) ... yrs. ... mos. 3 ... ds.

CONTRIBUTORY (Secondary)* Incarcerated inguinal Hernia (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Hernia Town

Did an operation precede death? Date of 11/14/24

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Dyer M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cemetery	Nov. 20 ..... 19 24
20-UNDERTAKER. H. Sander Sons	ADDRESS 1210 Fleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

92103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1929 D 92103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N Durham ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Chase

(a) RESIDENCE. NO. 421 N Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
86				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha Chase

(Address) 201 N Carrollton St

15 Filed NOV 18 1924 19 ROBERT R. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1924, to Nov 16, 1924, that I last saw h. alive on Nov 15, 1924 and that death occurred, on the date stated above, at 4 4, m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis Disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Barnes, M. D.

Nov 17, 1924 (Address) 2011 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	Nov 18 1924

20 UNDERTAKER Edward Bryson ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 18 1924

Spec.—1-10-21—M&T—1500 Bks.

D 92104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 E. monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas York.

(a) RESIDENCE NO. 1617 E. Monument st., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colord	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) mobile - ala. Ala.

PARENTS

10 NAME OF FATHER Thomas York

11 BIRTHPLACE OF FATHER (city or town) (State or country) ala

12 MAIDEN NAME OF MOTHER mary smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ala

14 Informant dora york
(Address) 1617 E mountment st

15 Filed NOV 18 1924 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-1924

17 I HEREBY CERTIFY, That I attended deceased from 9-10-, 1924, to 11-15-, 1924, that I last saw h alive on 11-14-, 1924, and that death occurred, on the date stated above, at 12,10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) dont know. yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) dont know. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Cargile, M. D.

11/15, 1924 (Address) 611 - N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: laurel cemetery — DATE OF BURIAL: nov 19 1924

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 orleans st

BURIAL PERMIT ISSUED

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92105

74-001

CERTIFICATE OF DEATH.

REGISTERED NO. D 92105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 E. 21th. St., ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Sanders

(a) RESIDENCE. No. 322 E. 21th. St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Sanders

6 DATE OF BIRTH (month, day, and year) June 10, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co., Md.

PARENTS

10 NAME OF FATHER George B. Sanders.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emily Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Wm. D. Hickey
(Address) 322 E. 21th. St.,

NOV 18 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924 to Nov. 16th 1924 that I last saw h[illegible] alive on Nov. 16, 1924 and that death occurred, on the date stated above, at 5. 15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis and Apoplexy

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis etc.

(Signed) J. B. Delvalle, M. D.

, 19 (Address) 710 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 19 1924
20 UNDERTAKER	ADDRESS
Nelson E. Stiles	320 Md. Ave Westport

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH is very important. See instructions on back of certificates.

D 92106 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92106

CERTIFICATE OF DEATH.

1 129

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 419 S. Collington Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Blusiewicz

(a) Residence No. 419 S. Collington Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Not known

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

11- (Informant), John Blusiewicz

(Address) 419 Collington Ave

15- NOV 18 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

In plain terms, so that it may be properly understood. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 16. 24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1. 24 19 to Nov. 16 19 24

that I last saw h— alive on Nov. 16 19 24

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchyneumonia Nephritis

(Duration) yrs. 2 mos. 12 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J. Maynard M. D

Nov 17 24 (Address) 1801 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL. Nov 19 1924

20-UNDERTAKER, F. W. Ozazewski ADDRESS 1930 Eastern

Spec.—8-24-14—M. & T.—2000 Blks.

D 92107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 N. Washington ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Krupsel

(Residence in Baltimore: No. 1108 N. Washington St.; 31 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Nov. 27, 1874 (Month) (Day) (Year)

7-AGE. 49 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Music Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Martin Krupsel

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Mary Bosta

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace K. Emmayer

(Address) 1108 N. Washington St.

15-

Filed NOV 18 1924, 19.... ROBERT R. KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH must be plainly and fully stated. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1924, to Nov. 15, 1924, that I saw him alive on Nov 15th, 1924, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Larynx

(Duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) ..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Chas W. Stevage M. D.

Nov 17th, 1924 (Address) 1729 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	Nov. 19, 1924
20-UNDERTAKER	**ADDRESS**
Henry Hoeck Son	1301 E. Eager St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92108

CERTIFICATE OF DEATH.

45

D 92108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 N. Dolf ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen McConnell

(a) RESIDENCE NO. 2029 N. Dolf. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Mrs Elizabeth McConnell

6 DATE OF BIRTH (month, day, and year) Nov. 22 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	51	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical 029

(b) General nature of Industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER William McConnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Miss. McCready

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Elizabeth McConnell

(Address) 2029 N Dolf St.

15 Filed NOV 1 1924 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17 1924

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to Nov 17, 1924, that I last saw him alive on Nov 17, 1924, and that death occurred, on the date stated above, at 1 45 a. m.

The CAUSE OF DEATH* was as follows:

Rolio pericardial Sarcoma

(duration) 1 yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Wassermann

(Signed) [illegible], M. D.

Nov 17, 1924 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov 19 1924

20 UNDERTAKER	ADDRESS
Henry Heath Son	1509 E Eager St

Information should be carefully supplied; it may be properly classified. Write plainly and use ink. Be sure that it may be properly classified. Write plainly and use ink. Be sure that it may be properly classified. Write plainly and use ink. Be sure that

Spec—12-23-21—E.B.R.S.—400 Blks.

BROWN

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92109 D 92109

CERTIFICATE OF DEATH.

14 +90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2327 Division St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Samuel Brown

(a) Residence No. 2329 Division St., Ward Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6-DATE OF BIRTH (month, day and year) Feb 15 1872

7-AGE 52 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Don't Know

9-BIRTHPLACE (city or town) (State or Country). Washington D. C.

PARENTS.

10-NAME OF FATHER, Edward Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Charles Co Md

12-MAIDEN NAME OF MOTHER, Ramona Baker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Sarah Brown
(Address) 2324 Division St

15- Filed NOV 18 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 1924 to Nov 14 1924 that I last saw h.. alive on Nov 10 1924 and that death occurred, on the date stated above, at 10A .m. The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Mitral Insufficiency

(Duration) 4 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D

11-17 1924 (Address) 1919 E. Monument St City

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Potters Field	Nov 18 1924
20-UNDERTAKER.	ADDRESS.
Joseph Frank	1919 E Monument St

In pursuance of law, see other instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92110

D 92110

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 W. Lafayette Ave ST.; 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Anderson

(a) RESIDENCE. NO. 7 W. Lafayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Dont know.

7 AGE: Years: Aprox. 68 Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bells Md.

PARENTS

10 NAME OF FATHER: Jacob Gumm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Dont know 11/17 1924

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Beatrice Cole.
(Address) 7 W. Lafayette

15 Filed . 19 Registrar

NOV 18 1924 ROBERT R. KRAUS Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Nov 15, 1924, that I last saw h alive on Nov 15, 1924, and that death occurred, on the date stated above, at 2.45 P.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Miles Wheeler, M. D.

(Address) 2129 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn.	Nov 18 1924
20 UNDERTAKER	ADDRESS
Mrs P. C. Elliott.	1227 Eastland ave

THIS is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92111

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 92111

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1210 Light St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph D. Hangmann.

(a) Residence No. 1210 Light St. (Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) July 25 1890

7-AGE, 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Anton Hangmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Bertha Rholam

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Anton Hangmann.

(Address) 1210 Light St

NOV 18 1924

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 17/24

17- I HEREBY CERTIFY, That I attended deceased from 9.1.24, 19.. to 11.17, 19.24

that I last saw h.m alive on 11.17. 19.24

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Physical findings

(Signed) J. Edward Lomas M. D.

11/18/24 (Address) 107 E. West St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cem. — DATE OF BURIAL. 11-20 19.24

20-UNDERTAKER. Ernest Harlan — ADDRESS 115 E West St

Should be carefully examined as to correctness of every statement, and signed in ink. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92112

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Montebello Ave. ST., 9 WARD)

2-FULL NAME Jerome Andrew Yakel

(a) RESIDENCE NO. 2206 Montebello Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha C. Werner

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Community Hard-

(c) Name of employer ware Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Anthony Yakel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bernadine ----

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Gustave F. Yakel
(Address) 2407 N. Calvert St.

15 Filed NOV 18 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924, to Nov 17, 1924, that I last saw him alive on Nov 17, 1924, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2-3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Nephritis

(Signed) Walter C Bacon, M. D.

11/17 1924 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 11/20 1924

20 UNDERTAKER Henry U. Mears & Son — ADDRESS 805 N. Calvert

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92113

CERTIFICATE OF DEATH.

D 92113

Registered No. 101

1-PLACE OF DEATH

City of BALTIMORE: (No. 2935 Reese St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis William Leight

(a) Residence No. 2935 Reese St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth E. Smuck

6-DATE OF BIRTH (month, day and year) Jan. -----

7-AGE, 82 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Lawrence Leight

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Wilhelmina -----

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Walter H. Leight

(Address) 2935 Reese Street

15- Filed NOV 18 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9 19 24, to Nov. 15 19 24, that I last saw h~~e~~ alive on Nov. 15 19 24, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Prentiss M. D.

11.17, 1924 (Address) 634 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. John's Cemetery, Waverly. DATE OF BURIAL. 11/18/24

20-UNDERTAKER. Henry W. Myers & Son ADDRESS 805 N. Calvert

Exact statement of OCCUPATION is very important. Be sure it is plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92114

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 S. Lakewood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lindeman

(a) Residence No. 514 S. Lakewood St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Robena Lindeman

6-DATE OF BIRTH (month, day and year) Jan. 1851

7-AGE. 73 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Lindeman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Robena Lindeman (Wife)
(Address) 514 S. Lakewood Ave

15- Filed NOV 18 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1924 to Nov. 17 1924, that I last saw h.. alive on Nov. 16 1924 and that death occurred, on the date stated above, at 9 50 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Numerous (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C B Britton, M. D.

, 19 (Address) 3316 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel Cem. DATE OF BURIAL. Nov. 18 19 24

20-UNDERTAKER. Lilly & Zuller ADDRESS 403 S. Wolfe St

Exact statement of OCCUPATION is necessary. Use words commonly understood. Avoid abbreviations. Write in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is necessary. Use words commonly understood. Avoid abbreviations. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B R.S.—400 Bks.

D 92115 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92115

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 Sharpe St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Wilkes

(a) Residence No. 1121 Sharpe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single.

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11-15-24

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 9 hrs. 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... nil

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Balto., Md.

PARENTS.

10-NAME OF FATHER, Samuel Wilkes

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER Florence Cousers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) S. Carolina

14- (Informant) Florence Wilkes

(Address) 1121 Sharpe St.

15- Filed NOV 18 1924, 192.. Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-15-24

17- I HEREBY CERTIFY, That I attended deceased from 11-15 1924 to 11-15 1924

that I last saw h[illegible] alive on 11-15 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. Alexander Norris M.D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. of Md. DATE OF BURIAL, ... 19..

20-UNDERTAKER. ..... ADDRESS .....

NOV 18 1924 Dept. of Health

For Wm. R. Woods

In plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92116

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 N. Monroe St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Elizabeth Smith

(a) Residence No. 1313 N. Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, black

5-Single, Married, Widowed, Divorced. (Write the word.) Single.

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11-4-24

7-AGE. ....yrs. ....mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) dec

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto., Md.

PARENTS.

10-NAME OF FATHER Joseph Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Edna Cure

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Edna Smith

(Address) 1313 N. Monroe St.

15- Filed ..... 192.... Robert P. Harrison, Registrar.

NOV 1924 Curtis Bruce Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 16/24.

17- I HEREBY CERTIFY, That I attended deceased from 11-4 ....., 19 24, to 11-16 19 24

that I last saw h.. alive on 11-16 19 24

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. University of Md.

DATE OF BURIAL, ... 19....

20-UNDERTAKER.

ADDRESS

UNIVERSITY OF MARYLAND.

NOV 18 1924

In plain terms, so that writing may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D. 92117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 92117

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 4815 Delaware Av ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton A. Price

(a) RESIDENCE No. 4815 Delaware Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	11.		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER W. Price

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ankrum

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant C. W. Howard
(Address) 4815 Delaware Av

15 NOV 18 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and by autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D.
(Coroner.)
Nov 15, 1924 (Address) 3692 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	11-19 1924
20 UNDERTAKER H. C. Brauning & Son	ADDRESS 617 N Schroeder St

NOV 18 1924

Robert F. Hartman
Assistant Transit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST., 27 WARD)

2-FULL NAME Norma Bowman Bowen

(a) RESIDENCE NO. Edgewood Apts Harford Rd WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Wilmer Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 18 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 - 1924

17 I HEREBY CERTIFY That I attended deceased from Nov 15 - 1924 to Nov 16 1924, that I last saw him alive on Nov 16 1924, and that death occurred, on the date stated above, at 10:20 m.

The CAUSE OF DEATH* was as follows:

Erysipelas (facial) + sepsis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Septicaemia (haemolytic streptococcus)

(duration) yrs. mos. 2 ds.?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) Edmund W. Kerper, M. D.

11/17, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ebenezer Cemetery Chase Sta

DATE OF BURIAL: 11/19/24 19

20 UNDERTAKER: George J. Watts

ADDRESS: 1035 Hanover

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92119

D 92119

CERTIFICATE OF DEATH

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST., 6 WARD)

2-FULL NAME Mr Robert A. ~~Smith~~ Schmidt

(a) RESIDENCE No. 2207 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year): Jan. 10. 1867

7 AGE: Years 55 | Months 10 | Days 6 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: School Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

068

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Andrew Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada

12 MAIDEN NAME OF MOTHER: Wilhelmina Fleck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Robt A Smith Schmidt

(Address) 2207 E Oliver

Filed ... 19 ... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 5:30 PM 11/16. 1924. to 11:03 PM. 11/16. 1924.

that I last saw him alive on 11/16 (11:03 PM) 1924.

and that death occurred, on the date stated above, at 11:03 p m.

The CAUSE OF DEATH* was as follows:

Generalized malignant growth.

of carcinoid and mediastinal glands.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Tracheal & Bronchial Obstruction (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical

(Signed) Jno A Lanahan M. D.

19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Nov 19 1924

20 UNDERTAKER: Henry Lutz

ADDRESS 203 N Broadway

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

NOV 1 9 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92120

24-001

D 92120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1853 N. Pratt ST., 19 WARD)

2-FULL NAME Teresa Morena

(a) RESIDENCE NO. 1853 N. Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Enrico Battaglia

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Fiorenco

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Dan Morena
(Address) Eastland - Md

15 Filed NOV 18 1924, 192 Robert P. Harrison Registrar

NOV 18 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 - 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisitory (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisitory (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Instantaneous

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)
, 192 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 19 1924
20 UNDERTAKER	ADDRESS
Mr. Mrs. H. S. Pinsk	1732 N. Chas. St

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92121

D 92121

CERTIFICATE OF DEATH.

8 24

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1114 N. Washington ST.; 8 WARD)

2-FULL NAME Sarah J. Frazier

(a) RESIDENCE. No. 1114 N. Washington ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George E. Frazier

6 DATE OF BIRTH (month, day, and year) May 24th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Stewart

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Rachel Macalister

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland.

14 Informant Mr. Henry M. Stewart
(Address) 1114 N. Washington St.

15 Filed ..... 19 ..... Robert P. Harrison
Registrar

NOV 18 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 15th 1924 to Nov 17th 1924,

that I last saw h.. alive on Nov 17th 1924,

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Kelly, M. D.

Nov 18, 1924 (Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	11/20 1924

20 UNDERTAKER Liston P. Fussellaugh ADDRESS 2620 St Paul St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 92122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. First St. and Druid Ave. ST. 27 WARD) (Mt Washington)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Centz Gosnell

(a) RESIDENCE NO. 1 First St. and Druid Ave ST. 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna D Gosnell

6 DATE OF BIRTH (month, day, and year): Sept 14 1857

7 AGE: Years 67 Months 2 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk. Dept Store

(b) General nature of industry, business, or establishment in which employed (or employer): 6004

(c) Name of employer: Hirschhorn Kohn & Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catharine Centz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John Leonard Gosnell

(Address) Baltimore Md

15 Filed NOV 18 1924 19 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1924, to Nov 17, 1924.

that I last saw him alive on Nov 16, 1924.

and that death occurred, on the date stated above, at 8 am m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Enlarged Heart

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina

(duration) yrs. mos 3 wks ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. A. Todd, M. D.

11/19, 1924 (Address) Mt Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 20 1924

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Falls Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92123

CERTIFICATE OF DEATH.

101-001

D 92123

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 East 29th ST., 9 WARD)

2-FULL NAME Edward G. Carr

(a) RESIDENCE NO. 631 East 29th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child gps

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Howard A. Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chester Pena

12 MAIDEN NAME OF MOTHER: Edith R. Wrightson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Howard A Carr
(Address) 631 - E - 29th

15 Filed NOV 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Cert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1924, to Nov. 17, 1924, that I last saw him alive on Nov. 17, 1924, and that death occurred, on the date stated above, at 1010 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos A Stevens, M. D.

11/18, 1924 (Address) 2878 Stanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Nov 19 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Mn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92124

CERTIFICATE OF DEATH.

90 ✓ D 92124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1800 Rosedale ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Powell

(a) RESIDENCE No. 1800 Rosedale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Wood product

(c) Name of employer Company 014

9 BIRTHPLACE (city or town) (State or country) Md - Balto

PARENTS

10 NAME OF FATHER Charles E Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Balto

12 MAIDEN NAME OF MOTHER Julia A. Barth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Balto

14 Informant Charles E Powell
(Address) 1817 N. Fulton

15 Date NOV 19 1924 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 7" 19 24, to Nov 17 19 24, that I last saw h alive on Nov 17 19 24 and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. A. Duvall, M. D.

11-17, 19 24 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov 19 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

MAHGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92125 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92125

CERTIFICATE OF DEATH.

1294

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Ragner ave & Dukeland ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr James Attinson -

(a) RESIDENCE NO. 516 N Pine ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sexton 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Methodist Church.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George R. Attinson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Brother Imerio B. Attinson
(Address) 516 N Pine St.

15 Filed NOV 19 1924 ROBERT R. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/15, 1924, to 11/17, 1924, that I last saw him alive on 11/17, 1924, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia - Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Clement. R Monod, M. D.

, 19 (Address) West Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 11-14 1924

20 UNDERTAKER Helen A. Holland — ADDRESS 1631 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92126

CERTIFICATE OF DEATH.

12 92126

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Argyle ave ST., 17 WARD)

2-FULL NAME James Cole.

(a) RESIDENCE NO. 1211 Argyle ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	73		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Benjamin Cole.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Camper Arkwood

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Martha Hammond
(Address) 1211 Argyle ave.

15 Filed NOV 19 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from 25/10, 1924, to 16/11, 1924, that I last saw h[illegible] alive on 14/11, 1924, and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis

Several weeks

(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Mayfield Hoff M. D.

17/11, 1924 (Address) 417 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interlachen Cem. — DATE OF BURIAL 11-13 1924

20 UNDERTAKER George T. A. Gibson — ADDRESS 1735 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

176184

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 92127

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

D 92127

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Stein

(a) RESIDENCE NO. 19 N. Washington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1902

7 AGE — Years: 2 — Months: 3 — Days: 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samuel Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Jennie Jutkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1924 to Nov 18, 1924.

that I last saw h~~im~~ alive on Nov 18, 1924.

and that death occurred, on the date stated above, at 10.25 a.m.

The CAUSE OF DEATH* was as follows:

Primary (lobar) pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Pericardial effusion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Walter B. Stewart M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cem Work Rd

DATE OF BURIAL: 11/19 1924

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto

Cor.—1-12-23—M&T—100 Blks.

D 92128

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 92128

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

2-FULL NAME Susan Williams

(a) RESIDENCE NO. 1115 Hollins ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Williams.

6 DATE OF BIRTH (month, day, and year) May 7th 1884

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work (Housewife)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr. John E. Williams
(Address) 1115 Hollins St.

15 Filed ..... 192 ..... Registrar

NOV 19 1924 ROBERT B. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Two days (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ....., M. D.

Nov 19, 192 (Address) 309 Lex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Years

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral S. Clerg	Nov. 21 1924
20 UNDERTAKER Conway Lord	ADDRESS
901 Hollins Per J. Conway	901 Hollins St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Presbury ST. 15 WARD)

2-FULL NAME Emma Litsinger

(a) RESIDENCE NO. 2700 Presbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Towson
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Litsinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Hook

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Emma E. Waters
(Address) 2700 Presbury St.

15 Filed NOV 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D. (Coroner.)

Nov. 18, 1924 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cemetery

DATE OF BURIAL 11/19 1924

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Cor.—1-12-23—M&T—100 Bks.

92130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (Street) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Burkett W. Legg

(a) RESIDENCE NO. 3309 Elm ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Amos E. Legg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Criswell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hugh V. Legg
(Address) 33 11 Elm Ave

15 Filed ..... 192 ..... Registrar

NOV 19 1924 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

6 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto accident

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.

(Coroner.)

, 192 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for Coroner's Notice.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Christian Cemetery Holland Co.	Nov 21 1924
20 UNDERTAKER Chenowith & Son	ADDRESS 365 Fremont Ave

NOTE—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92131

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-801 D 92131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 305 N Stricker St., 19 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dorsey

(a) Residence No. 305 N Stricker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William Dorsey

6-DATE OF BIRTH (month, day and year) Mar 1846

7-AGE. 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, John Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Margaret Dorsey

(Address) 305 N Stricker St

13- FILED NOV 19 1924 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1924 to Nov 17 1924

that I last saw h alive on Nov 16 1924

and that death occurred, on the date stated above, at 3.30 a.m. on

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Autopsy

(Signed) [illegible] M. D

, 19 (Address) 1125 Mary Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery Jackson Chapel. DATE OF BURIAL. Nov 20 1924

20-UNDERTAKER. Emmert L Wright ADDRESS 364 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Benjamin Fried

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92132

CERTIFICATE OF DEATH.

44 ✓ D 92132

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1810 E. Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME B. Fried

(a) Residence No. 1810 East Lombard Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Fried

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 72 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Peddler 65

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore

15- Filed NOV 19 1924 ROBERT R. KNAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/18/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 19 24 to Nov. 18 19 24

that I last saw h. alive on Nov. 18 19 24

and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lucille Lowe M. D.

, 19 (Address) 1810 Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL/CREMATION OR REMOVAL. Hebrew Hevrung Rest DATE OF BURIAL. 11-19- 1924

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE

Cor.—1-12-23—M&T—100 Bks.

D 92133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99 D 92133

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 330 N. Bruce ST., 19 WARD)

2-FULL NAME John Weadon

(a) RESIDENCE NO. 330 N. Bruce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Albert Weadon

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Priscilla Harper

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Carrie Stewart
(Address) 716 Dolphin St

15 Filed NOV 19 1924 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

, 192 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for ...

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	11/19 1924
20 UNDERTAKER Walter B. Spriggs	ADDRESS 11. Schroder St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92134

CERTIFICATE OF DEATH.

47 D 92134

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Bennett Place ST., 18 WARD)

2-FULL NAME Lottie Robinson

(a) RESIDENCE NO. 1006 Bennett Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex. Robinson

6 DATE OF BIRTH (month, day, and year) Sept 21, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alex. Merchant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. G. Whitney

(Address) 1006 Bennett Place

15 Filed NOV 19 1924 ROBERT B. KRAUTER Registrar

Burial Permit Mailed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17

I HEREBY CERTIFY, That I attended deceased from April, 1924 to Nov. 17, 1924.

that I last saw h alive on Nov 17, 1924.

and that death occurred, on the date stated above, at 12 00 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? resp

(Signed) W. H. Lucas, M. D.

(Address) 3326 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 20 1924
20 UNDERTAKER	ADDRESS
Chas. Mitchell	1201 N. Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92135

CERTIFICATE OF DEATH.

74-001

D 92135
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1615 Park Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Cannaw

(a) RESIDENCE No. 1615 Park ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Cannaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): D Md

12 MAIDEN NAME OF MOTHER: Loueretia Auld

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sylvia Helgen

(Address) 1615 Park Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

NOV 19 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18. 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2 , 1924, to Nov. 18 , 1924, that I last saw her alive on Nov. 18 , 1924 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross clinical & laboratory

(Signed) Bernard Farrell Muse M. D.

11/19/, 1924 (Address) 103 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Nov. 1924

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92136

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Union Memorial Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos Gregory Start

(a) RESIDENCE NO. 11-E-Chase ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 71 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mayard Classen Start

6 DATE OF BIRTH (month, day, and year): About 1853

7 AGE — Years: 71 — Months: ? — Days: ? — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Solomon Start

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Lydia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland.

14 Informant: Mrs Chas. E. Buddell (Niece)

(Address) 3104 Presbury St.

15 Filed NOV 19 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov 8 , 19 24 , to Nov 17 , 19 24 ,

that I last saw h[illegible] alive on Nov 17 , 19 24

and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ..... yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) A. Austin Pearre, M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Nov 19 19 24

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Eks.

Spinner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92137

CERTIFICATE OF DEATH.

38 D 92137

Registered No.....

1-PLACE OF DEATH St. Joseph's Hospital 3

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Spinner

(a) Residence No. 221 South Bethel St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ethel Spinner

6-DATE OF BIRTH (month, day and year) Mar 18 1867

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Alabama

PARENTS

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown.

11-(Informant) Ethel Spinner

(Address) 221 S. Bethel

15-Filed NOV 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 7, 1924 to Nov 17, 1924

that I last saw h. ~~alive~~ on Nov 17, 1924

and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Syphilis

(Duration) 3 yrs. x mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) x yrs. x mos. 10 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) G. B. Seybert M. D.

, 19 (Address) W Saratoga Sts

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL, Nov 20 1924

20-UNDERTAKER, Mrs P. G. Elliott — ADDRESS 1526 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92138

CERTIFICATE OF DEATH.

31

D 92138

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 W. Conway St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ziginski

(a) Residence No. 640 W. Conway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Sigle

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Sept. 17. 1890

7-AGE.	If LESS than 1 day,
34 yrs. 2 mos. – ds.	hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Talor

(b) General nature of industry, business, or establishment in which employed (or employer) – –

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, George Ziginski

11-BIRTHPLACE OF FATHER (city or town) Lithvania
(State or Country),

12-MAIDEN NAME OF MOTHER, Rose Lukasaviez

13-BIRTHPLACE OF MOTHER (city or town) Lithvania
(State or Country),

14- (Informant) George Zigiński
(Address) 640 W. Conway Street

15- NOV 19 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 17. 1924

17- I HEREBY CERTIFY, That I attended deceased from June 8 19 24 to Nov. 17 19 24

that I last saw h.. alive on Nov. 17 19 24

and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Edward V. Cochran M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	NOV. 20, 1924
20-UNDERTAKER.	**ADDRESS**
John Grebliauckas	425 S Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Dare.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92139

CERTIFICATE OF DEATH.

90 D 92139

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 555 Orchard ST., 17 WARD)

2-FULL NAME Eliza Dare

(a) RESIDENCE No. 555 Orchard ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Dare

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Robert Chinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Potts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Family, Chinn

15 Filed NOV 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 9/16 1924 to 11/16/24 1924 that I last saw h.. alive on 11/13 1924 and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Cystitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? 68 Brookmont

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) De Lee Chinn M. D.

19 (Address) 52 Orchard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov. 19 1924

20 UNDERTAKER Samuel D. Hawley ADDRESS 778 Eddy St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

William W Ramsay.

D 92140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92140

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raynor ave & Rutland ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr W W Ramsay

(a) RESIDENCE NO. Amondale Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Edwin Ramsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Kirkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Catherine E Ramsay

(Address) Amondale Md

15 Filed OCT 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/13, 1924, to 11/17, 1924, that I last saw h— alive on 11/17/, 1924, and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocardial Failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Clement R. Merrel, M. D.

, 19 (Address) West Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL, CREMATION~~ OR REMOVAL St Joseph Cemetary

DATE OF BURIAL Nov 20 1924

20 UNDERTAKER Edward Fuller

ADDRESS Govd Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92141

CERTIFICATE OF DEATH.

D 92141

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 504 E Clement St., 24 (WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Neumann

(a) RESIDENCE No. 504 E Clement St., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper Neumann

6 DATE OF BIRTH (month, day, and year) D. 30. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	76	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heman Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lizzie Jewell

(Address) 504 E Clement St

15 Filed NOV 19 1924, Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11.17 1924

17 I HEREBY CERTIFY, That I attended deceased from 11.16, 1924, to 11.17, 1924, that I last saw her alive on 11.17, 1924, and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. J. Burlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: 20 1924

20 UNDERTAKER: J. Fred McCully ADDRESS: 1305 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92142

CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Adele Rossman

(a) RESIDENCE NO. 1221 Pulteland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George A. Rossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Pauline Truss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant George A Rossman

(Address) 1221 Pulteland Ave.

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/13 . 1924 . to 11/16 . 1924 .

that I last saw her alive on 11/16 . 1924 .

and that death occurred, on the date stated above, at 11.55 .m.

The CAUSE OF DEATH* was as follows:

Epidemic encephalitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) Geo A Rossman Emil, M. D.

. 19 (Address) 11 S Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 20 1924
20 UNDERTAKER George L. Schwab	ADDRESS 1101 Fulton Ave.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—T

Nov 19 1924

Robert P. Bartlow, Deputy Health Clerk.

MARGIN RESERVED FOR BINDING

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001 ✓

D 92143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., 20 WARD)

2-FULL NAME Lillian Batzer

(a) RESIDENCE NO. 419 S. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Emil Batzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katie Mahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Batzer (Address) 419 S. Mulberry St. Balt. Md.

15 Filed ....., 19 ..... Robert F. Martin Registrar

NOV 19 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1924

17

I HEREBY CERTIFY, That I attended deceased from October 30, 1924, to November 18, 1924, that I last saw her alive on November 18, 1924 and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) 0 yrs. 0 mos 14 ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Xray

(Signed) A. Austin Peters, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cemetery DATE OF BURIAL Nov. 20 1924

20 UNDERTAKER George A. Schnabel ADDRESS 901 Eutaw

D 92144

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 D 92144

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2 Prospect Ave Ward 27)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Barbara Beckman

(Residence in Baltimore: No. 2 Prospect Ave Raspeburg 5 yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feby 4, 1860 (Month) (Day) (Year)

7 AGE: 64 yrs. 9 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Geo Feudel

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Hoffman

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Wm D Corse

(Address): Corse & Southern

15 Robert F. Harriss

Dec 191

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 18, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924, to Nov 18 1924

that I saw h[illegible] alive on Nov 18, 1924

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Phthisis

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY): Exhaustion

(Duration) yrs. mos. ds.

(Signed) Wm D Corse M. D.

Nov 18, 1924 (Address) Corse & Southern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d

Where was disease contracted, if not at place of death? Na Known

Former or usual residence 2 Prospect Ave

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: Nov. 21, 1924

20 UNDERTAKER: Fredk Lasselmann Sons

ADDRESS: Fullerton

NOV 19 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

D 92145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92145

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 N Broadway ST., 8th WARD)

2-FULL NAME Harry Scott Alt

(a) RESIDENCE No. 1611 N Broadway ST., WARD 8
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ruby V. Alt.

6 DATE OF BIRTH (month, day, and year) Aug 3rd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer and

(b) General nature of Industry, business, or establishment in which employed (or employer) Compositer 063

(c) Name of employer Faulkner & Co

9 BIRTHPLACE (city or town) (State or country) Towson Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Brother in Law Mrs. (Address) H E Hausten Overlea

15 NOV 19 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Tues. Nov. 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany. 18, 1924, to Nov. 18th, 1924, that I last saw him alive on Nov. 17, 1924, and that death occurred, on the date stated above, at 3 oclock m.

The CAUSE OF DEATH* was as follows:

a Cancerous growth in Cervical region with pressure on Carotid artery

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Paralysis (Hemaplegia)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his home

Did an operation precede death? Yes Date of 7 March 1923 Hopkins Hospital

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Test.

(Signed) Thomas F Dowden, M. D.

, 19 (Address) 1016 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cemetery	Nov. 20, 24
20 UNDERTAKER	**ADDRESS**
Fredk Lansdale Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92146

D 92146

CERTIFICATE OF DEATH.

X 57

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2201 W Lexington St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME. Margaret F. Martin

(a) Residence No. 2201 W Lexington St., Ward 26th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Paul J Martin

6-DATE OF BIRTH (month, day and year) Jan 8 1855

7-AGE. 69 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). 0

(c) Name of employer. 0

9-BIRTHPLACE (city or town) (State or Country), Washington D. C.

PARENTS.

10-NAME OF FATHER, Chas W. Koch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophia Fassnacht

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant, Paul Martin

(Address). 2201 W Lexington St

15-Filed NOV 10 1924 Robert P. Harrison, Registrar.

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 19 1924

17-I HEREBY CERTIFY, That I attended deceased from Nov. 13 1924 to Nov. 18 1924, that I last saw h[illegible] alive on Nov. 18 1924, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 7 yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Washington DC

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Examination

(Signed) M. Hamm, M. D.

, 19 (Address) 16 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Friendship Cem. | DATE OF BURIAL. Nov 21 1924

20-UNDERTAKER. Geo A. Little | ADDRESS Edmondson Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92147

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 420 N. Castle St. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mildred Krieger

(a) Residence No. 420 N. Castle St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 25, 1924

7-AGE.	If LESS than 1 day,
.....yrs. 5 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Eugene Krieger

11-BIRTHPLACE OF FATHER (city or town). Balto. Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Anna Merchant

13-BIRTHPLACE OF MOTHER (city or town)..... Maryland
(State or Country),

14- (Informant)..... Mrs. Anna Krieger
(Address)..... 420 N. Castle St

15- Filed 9 1924 Robert P. Harrison Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). November 19/24

17- I HEREBY CERTIFY, That I attended deceased from October 30 19 24, to November 18 19 24

that I last saw h.. alive on November 18, 19 24

and that death occurred, on the date stated above, at 8.10A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Ayd, M. D.

Nov 19, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Pimlico Cem	Nov 20, 1924
20-UNDERTAKER,	ADDRESS
Geo. M. Smith & Son	844 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Gijinski)

D 92148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 901

D 92148

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Giginski

(a) RESIDENCE No. 1251 S. Hacken ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day,.....hrs. or ... min.
55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Municipal Hospital Records
(Address)

15 ROBERT P. HARTLEY

Filed 19

NOV 19 1924 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-15 1924 to 11-18 1924

that I last saw him alive on 11-17 1924

and that death occurred, on the date stated above, at 3:25 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude E. Dorsey M. D.

11-18 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 21 1924
20 UNDERTAKER	ADDRESS
John M. Weber	803 Bank St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92149

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE, (No. ..... ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Seff

(a) RESIDENCE NO. 3407 W Morris Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: M

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jenkins

7 AGE — Years: 58 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jeweler 038

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Jentown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Jentown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Levis

(Address): 1439 E Baltimore St

15 NOV 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1924, to Nov. 19, 1924, that I last saw him alive on Nov. 19, 1924, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 2 yrs. ..... mos ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinically & lab.

(Signed) Isidor J. Fry, M. D.

Nov. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery — DATE OF BURIAL: Nov 20 1924

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92150

CERTIFICATE OF DEATH.

47 D 92150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Quick Ave ST. 76 WARD) Fairmville

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie W. Lutz

(a) RESIDENCE NO. 8 Quick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. 7 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Charles Lutz.

6 DATE OF BIRTH (month, day, and year) November 12 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	26	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John J. Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Heilman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. John J. Ritter

(Address) 8 Quick Ave

15 Filed NOV 20 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19 1924

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1924, to Nov 19, 1924

that I last saw her alive on Nov 19, 1924

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

1 Primary Carcinoma Breast

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Hyps Cardio Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Thos Woldemey M. D.

Nov 20, 1924 (Address) 1900 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 22 1924
20 UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17499 D 92151

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-208 D 92151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Kozak

(a) RESIDENCE No. 2010 E Eager St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 14 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Kozak

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Carrie ?

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14

Informant .....
(Address) JOHNS HOPKINS HOSPITAL.

15

Filed NOV 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 16 - 1924 to Nov 19 - 1924.

that I last saw h alive on Nov 19 1924,

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) Edmund A. Kerper M. D.

11/17 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cem	Nov 21 1924
20 UNDERTAKER Philip Henry	ADDRESS 206 N. Wash

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92152

CERTIFICATE OF DEATH.

D 92152

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1024 E. Fayette St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Elfman

(a) Residence No. 1024 E. Fayette St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? 34 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Abraham M

6-DATE OF BIRTH (month, day and year) 1890

7-AGE, 34 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Moses Pinerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Potts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) M. Pinerman

(Address) 1024 E. Fayette St

15- Filed NOV 20 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 19/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1924, to Nov. 18, 1924, that I last saw her alive on Nov. 18, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of Ovaries

(Duration) 3 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Trenton N. J

Did an operation precede death? Yes Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) C. Eichenlaub M. D.

11/20 1924 (Address) 1412 Eight St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rising Sun — DATE OF BURIAL, 11/20 1924

20-UNDERTAKER, Sol Levinson & Bro — ADDRESS 112 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92153

101-001

D 92153

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 147 W. Hamburg ST.: 23 WARD)

2-FULL NAME Herbert Claflin Boyer

(a) RESIDENCE. No. 147 W Hamburg ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augusta Boyer

6 DATE OF BIRTH (month, day, and year) [illegible] 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Benj. Boyer

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) md

12 MAIDEN NAME OF MOTHER Maggie Broome

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) md

14 Informant Maggie Boyer
(Address) 147 Hamburg St

Filed NOV 20 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 , 1924 , to Nov 18 , 1924
that I last saw h[illegible] alive on Nov 18 , 1924
and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Arteriosclerosis 7

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H. Hewlett , M. D.

Nov 24 (Address) 712 S Stricker Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 21 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostell St

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92154 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92154

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 W. Hoffman 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Moulden

(a) RESIDENCE NO. 309 Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 21

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible] (State or country)

12 MAIDEN NAME OF MOTHER [illegible] 1918

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country)

14 Informant Edw Davis

(Address) 329 W Hoffman

15. Filed NOV 20 1924 ROBERT R. QUAILES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18th 1924 to Nov. 18th 1924

that I last saw h alive on Nov. 16th 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. L. Ellis, M. D.

Nov. 19 24 (Address) 1426 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 21 24
20 UNDERTAKER J. Wm. H. Toadvine	ADDRESS 1419 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

92155

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

D 92155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1006 Wagon alley St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Baby Boy Johnson.

(a) Residence No... 1006 Wagon alley St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, black.

5 Single, Married, Widowed, or Divorced (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11-17-24

7-AGE, ... yrs. ..... mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Phoebe Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14-

(Informant) Phoebe Johnson

(Address) 1006 Wagon alley

15-

Filed NOV 20 1924 ROBERT R. KRAMER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-19-24

17- I HEREBY CERTIFY, That I attended deceased from 11-17 1924 to 11-19 1924

that I last saw him alive on 11-19 1924

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary).....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?.....

(Signed) W. Alexander Norris M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Univ. of Md. DATE OF BURIAL, ... 19....

20-UNDERTAKER ..... ADDRESS .....

NOV 19 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

352

1958

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92156

CERTIFICATE OF DEATH.

90 D 92156

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 803 Woodyear ST. 16 WARD)

2-FULL NAME Alice R. Smith

(a) RESIDENCE NO. 803 Woodyear ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. dy.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 670

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER — Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Marie Alice Burns

(Address) 1341 E. Carey st

NOV 20 1924

ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1924, to Nov 18 1924.

that I last saw h.r alive on Nov 17th 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

of Heart

(duration) yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

11/19 1924 (Address) 1501 Freedman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cem	Nov 20 19
20 UNDERTAKER	ADDRESS
Edmund Hawley	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 92157

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 E. 24th St., 17 WARD)

2-FULL NAME DeWitt T. Caldwell

(a) RESIDENCE No. 410 E. 24th St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER [illegible] Caldwell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant [illegible] Caldwell (Address) 410 E. 24th St

15 Filed ....., 19..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1924, to Nov 18, 1924.

that I last saw h— alive on Nov 18, 1924.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ex. Sputum —

(Signed) P. Garland Stewart M. D.

Nov 20, 1924 (Address) 1334 - E. N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Nov. 20 19
20 UNDERTAKER	ADDRESS
Emmert & Ensley	N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hospital (St.) 19 (Ward)

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence J. Woodward

(a) RESIDENCE No. 500 N. Carey st (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Work
(b) General nature of industry, business, or establishment in which employed (or employer): Good
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Sr. J. Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs Cowpen
(Address): West Chester Pa

15 Filed NOV 20 1924, 192... Registrar: ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest & Internal Injuries

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(duration) yrs. mos. ds.

(Signed) H H Gunsel, M. D.
(Coroner.)

11-20, 192... (Address) 1127 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Chester Pa	Nov 21 192...
20 UNDERTAKER	ADDRESS
Chas. E. Franck	887 Madison E

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92159

CERTIFICATE OF DEATH.

188-003

188 D 92159

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) St. Agnes Hospital ST., (WARD) 13

2-FULL NAME Thos J. Curtis

(a) RESIDENCE NO. 3036 Cedar Av ST., 13th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte B Curtis

6 DATE OF BIRTH (month, day, and year) Aug 7th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) 057
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm T. Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie B. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charlotte B. Curtis
(Address) 3036 Cedar Ave

15 Filed NOV 20 1924 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Cerebral.

(duration) yrs. 15 hrs

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Fortney, M. D.
(Coroner)
, 192 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Nov 21 1924

20 UNDERTAKER Horace A. Burgee

ADDRESS 363 Fallsway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks. Alice J. Slonaker

D 92160 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH.

16 74-001 D 92160

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3255 E: Baltimore St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice J: Slonaker

(a) Residence No. 3255 E: Baltimore St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of David C: Slonaker

6-DATE OF BIRTH (month, day and year) 1/6/1858

7-AGE, 66 yrs. 10 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED at home

(a) Trade, profession, or particular kind of work 37

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Pennsylvania (State or Country).

PARENTS.

10-NAME OF FATHER, Saml Needy

11-BIRTHPLACE OF FATHER (city or town) Pa. (State or Country).

12-MAIDEN NAME OF MOTHER, Mary Schilling

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country).

14- (Informant) David C: Slonaker

(Address) 3255 E: Baltimore St

15- Filed NOV 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 18/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 22, 1924, to Nov 18, 1924, that I last saw h. alive on Nov 18, 1924, and that death occurred, on the date stated above, at 4 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with Subsequent Softening

(Duration) yrs. 1 mos. 27 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Total R. Hemiplegia Left Arm

(Signed) E. H. Cumings, M. D.

, 19 (Address) 1733 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge DATE OF BURIAL. Nov 20, 19 24

20-UNDERTAKER, John Ulrich ADDRESS 200 Pleasant

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

92161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74-001 D 92161

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry W. Heim

(a) RESIDENCE NO. 106 Bayard Place, Jacksonville, Fla. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) May 22, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Owner & Druggist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indianna

PARENTS

10 NAME OF FATHER John Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indianna

12 MAIDEN NAME OF MOTHER Irene Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indianna

14 Informant Mr. Irene Heim

(Address) Jacksonville Fla.

15 Filed NOV 20 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Nov 19, 1924, that I last saw him alive on Nov 19, 1924, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hamorrhage

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary) + Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? Yes Date of Nov 15, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Donald O'Haynder, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntingburg Indiana — DATE OF BURIAL Nov 20 1924

20 UNDERTAKER Henry Jenkins & Sons Co — ADDRESS Orchard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Karez.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92162

CERTIFICATE OF DEATH.

58-001

58 D 92162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 S. Broadway ST., V WARD)

2-FULL NAME Agnes Karez

(a) RESIDENCE NO. 825 S. Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-21-55

7 AGE 69 Years 10 Months 28 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Sabinik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Andrew Karez

(Address) 825 S. Broadway

15 NOV 20 1924 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19-1924

17 I HEREBY CERTIFY, That I attended deceased from September 4, 1924. to November 19. 1924.

that I last saw her alive on November 19. 1924.

and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cardiac Insuff.

(Signed) L. V. Sundelovich, M. D.

11. 19. 1924 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Nov. 22 1924

20 UNDERTAKER W. F. Sadowski ADDRESS 925 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92163

99-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1120 Burgundy ST. 21 WARD)

2-FULL NAME Elizabeth Rudolph

(a) RESIDENCE NO. 1120 Burgundy ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Rudolph

6 DATE OF BIRTH (month, day, and year) March 10 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lizzie League

(Address) 1125 S. Paca

NOV 20 1924

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19-1924

17 I HEREBY CERTIFY, That I attended deceased from 11-18-1924 to 11-19-1924

that I last saw her alive on 11-14-1924

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) old age

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stafford Swan, M. D.

19 (Address) 1227 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz

DATE OF BURIAL NOV 22 1924

20 UNDERTAKER Wm Cook

ADDRESS 512 E Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 92164

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3329 E. North ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Grubert

(a) Residence No. 3229 E. North ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Henry Grubert

6-DATE OF BIRTH (month, day and year) Jan 30, 1881

7-AGE 43 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS

10-NAME OF FATHER F. W. Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Emma M. Baierlein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

11- (Informant) Henry Grubert

(Address) 3229 E. north ave

15- Filed NOV 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924 to Nov. 18, 1924

that I last saw her alive on Nov. 17, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 5 1/2 hrs.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. 1 mos. 18 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?* None

(Signed) Thos. F. Sellers, M. D.

11/19, 1924 (Address) 2878 Harford rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Nov. 21, 1924

20-UNDERTAKER Zirkler & Zirkler — ADDRESS Eager 1134

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92165

CERTIFICATE OF DEATH.

D 92165

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1627 N. Montford Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Schultz

(a) Residence No. 1627 N. Montford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Harry Schultz

6-DATE OF BIRTH (month, day and year) July 18, 1876

7-AGE. 48 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER George Booth

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Bunner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14- (Informant) Harry Schultz

(Address) 1627 N. Montford

15- Filed NOV 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924 to Nov 18 1924

that I last saw her alive on Nov 17 1924

and that death occurred, on the date stated above, at 12.05 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. F. Herzog M.D. M. D.

Nov 19, 1924 (Address) 1305 N. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL, Nov. 21, 1924

20-UNDERTAKER. Fickler & Fickler

ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92166

CERTIFICATE OF DEATH.

90 D 92166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Madison Ave ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Chas. Lewis

(a) RESIDENCE NO. 1628 Madison Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. M. Lewis

6 DATE OF BIRTH (month, day, and year) June 30, 186

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

009

9 BIRTHPLACE (city or town) .....
(State or country) London

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) .....

14 Informant Mrs. Eliz. M. Lewis
(Address) 1628 Madison ave.

15 Filed NOV 20 1924, 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said enquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Nov. 19, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 11-22 1924

20 UNDERTAKER H. Brauning & Son — ADDRESS 517 N Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILM

Spec—12-23-21—E.B.R.S.—400 Bks.

Scheve

D 92167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 92167

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emilie Scheve

(a) Residence No. 610 Garrison Boulevard St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White German

5-Single, Married, ~~Widowed~~ Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of — Scheve

6-DATE OF BIRTH (month, day and year) Mar 22/1857

7-AGE. 67 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Kaaz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Henrietta Scheve

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Florence Moltz

(Address) 610 Garrison Blvd City

15- Filed NOV 20 1924 ROBERT R. McWHITE Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 19/1924

17- I HEREBY CERTIFY, That I attended deceased from November 10 1924 to November 19 1924

that I last saw ~~her~~ alive on November 19 1924

and that death occurred, on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Cecum - Bladder

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov 14 1924

Was there an autopsy?

What test confirmed diagnosis? Exploratory Operation

(Signed) L. W. Saunders M. D

19 (Address) Church Home Infirmary City

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cemetery	Nov 22 1924
20-UNDERTAKER. Harry K Almond	ADDRESS 4204 Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEE TAX

Spec.—1-10-21—M&T—1500 Bks.

D 92168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92168

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Pl. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clorinda D. Murphy

(a) RESIDENCE NO. 406 E. Inniss St (Usual place of abode) Salisbury N. C. ST., WARD

Length of residence in city or town where death occurred -- -- mos. ? ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced (or) WIFE of: Mr. Thos. Murphy

6 DATE OF BIRTH (month, day, and year): ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): New Orleans La.

PARENTS

10 NAME OF FATHER: ? Daubert

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Orleans La.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Orleans La.

14 Informant (Address): Thomas Murphy 406 E. Inniss St. Salisburg N.C.

15 Filed ... 19 ... Registrar: ROBERT R. KRAUTER

JUN 2 0 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924 to Nov. 19, 1924, that I last saw her alive on Nov. 19, 1924 and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma both ovaries

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Shock from operation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov. 1824

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Grant Ward. M. D.

19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asheville, N. C.

DATE OF BURIAL: 11/20 19 24

20 UNDERTAKER: Henry W. Myers and Son

ADDRESS: 805 N. Calvert

Via Penn & Southern Railroad - Escort - Mr. Thomas Murphy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DARK

Spec—12-23-21—E.B.R.S.—400 Eks.

D 92169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92169

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3705 Falls Road St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Blair Albrick

(a) Residence No. 3705 Falls Road St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank C Albrick

6-DATE OF BIRTH (month, day and year): June 30 1857

7-AGE: 67 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home 37

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Carlisle (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Wm Blair

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Eleanor Coyle

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Pa

14- (Informant) Mr Frank C Albrick

(Address) 3705 Falls Road

15- Robert P. Harrison, 10- Registrar.

NOV 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 21st 1922 to Nov. 19th 1924

that I last saw h.. alive on Nov 19th - 1924

and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

General Sclerosis and Stephritis

(Duration) 2 yrs. mos. ds

CONTRIBUTORY (Secondary) Odema Lung

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D

11/20, 1924 (Address) 846 W 36th St. Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lorraine Cem.	Nov. 22, 1924
20-UNDERTAKER,	ADDRESS
Wm J Pickuerson	North Pa

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

2-FULL NAME George Hathaway

(a) RESIDENCE No. 205 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkton, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed NOV 20 1924, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-3, 1918, to 11-18, 1924

that I last saw him alive on 11-18, 1924

and that death occurred, on the date stated above, at 9 00 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Chronic nephritis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sect.

(Signed) Claude C. Wood M. D.

11-18 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health.

NOV 20 1924

Dr. WM. F. KOPPISCH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

35-1

NOV 20 1924

1503

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92171

CERTIFICATE OF DEATH.

100-001

D 92171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Mt. Cullon Sts. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roscoe Peaker

(a) RESIDENCE NO. 1214 Mt. Cullon Sts. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Roscoe Peaker Dead

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Peaker

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Annie Peaker
(Address) 1214 Mt. Cullon St.

15 Filed NOV 20 1924, 192 Robert P. Harris Registrar

1961

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

(Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER Dept. of Health.

ADDRESS NOV 20 1924

Per. Wm. E. Woodall

NOV 20 1924

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL OR REMOVAL. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 92172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92172

CERTIFICATE OF DEATH.

198

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE. (No. Mersity Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrlus Sims

(a) RESIDENCE NO. Dont Know ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant None
(Address)

15 Filed Nov 20, 1924, 192
Robert P. Harrison, Registrar
By Carl Forell Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~was not held~~) thereon and from the evidence obtained by said (Inquest, autopsy ~~was not held~~) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(duration) yrs. 4 mos. Bye laws

CONTRIBUTORY (Secondary) Blow from ax in hands of Chas Baker (duration) Homicide ds.

(Signed) W. H. Forman, M. D. (Coroner.)

Nov 19, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER — Dept. Commissioner Health. — ADDRESS NOV 20 1924

Per. Wm. E. Woodall

345

Spec.—1-10-21—M&T—1500 Bks.

176287 D 92173

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Kylie Magruder

(a) RESIDENCE NO. Hartsville SC ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-6-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Luther Magruder

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Emile Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Parents (Address) .....

15 Robert P. Harrison, Registrar

NOV 20 1924 .19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 15 - 1924 to Nov 20 - 1924, that I last saw him alive on Nov 20 - 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus, - post meningitis

(duration) yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) unknown origin meningitis of

(duration) yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death? Hartsville SC

Did an operation precede death? No Date of Nov 20-24

Was there an autopsy? Yes

What test confirmed diagnosis? Path.

(Signed) Wakefield Mason M. D.

11/20 1924 (Address) 5111

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hartsville SC — DATE OF BURIAL: 11/20 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 320 Berry

Spec.—1-10-21—M&T—1500 Bks.

D 92174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92174

10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., V WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guida Giguere

(a) RESIDENCE NO. 527 S. Washington St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10 NAME OF FATHER Marion Giguere

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Guida Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montenero

14 Informant Father.
(Address)

15 Filed NOV 20 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1924, to Nov 20, 1924, that I last saw h.er alive on Nov 20, 1924 and that death occurred, on the date stated above, at 6.55 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria,
Laryngeal & Tracheal
(duration) yrs. mos 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Tracheotomy Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Myron G. Tull, M. D.

11/20 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Nov 21 19 24
20 UNDERTAKER F. H. Ozazewski	ADDRESS 1930 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 20 1924

Cor.—1-12-23—M&T—100 Bks.

(Bennett)

D 92175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92175

CERTIFICATE OF DEATH.

1924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 15 WARD)

2-FULL NAME Jas L. Bennett

(a) RESIDENCE No. 2601 Chelsea Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer Gus Klotz Co

9 BIRTHPLACE (city or town) (State or country) Sam Gove Pa

PARENTS

10 NAME OF FATHER Louis A Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury Md

12 MAIDEN NAME OF MOTHER Lillie Satterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salisbury Md

14 Informant Robt Brooks
(Address) Calhoun & Hollins

15 Filed ... 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 20 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest or inquiry.) thereon and from the evidence obtained by said (Inquest or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted

(duration) a few minutes mos. ds.

CONTRIBUTORY (Secondary) Accidental Contact with Live Wire mos. ds.

(Signed) H. K. Fenwick, M. D. (Coroner.)

11-20, 1924 (Address) 117 N Davidge St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	11-24 1924
20 UNDERTAKER	**ADDRESS**
Robt Brooks & Son	Calhoun & Hollins

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92176 D 92176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore & Payson 90

CITY OF BALTIMORE: (No.) German Aged Home (St.) (Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Schmidt

(a) RESIDENCE. No. German Aged Home St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Schmidt

6 DATE OF BIRTH (month, day, and year): April 16 1850

7 AGE — Years: 74 — Months: 7 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frederick Ellenbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Barbara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: German Aged Home (Address) Balto & Payson Sts.

15 Filed NOV 20 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19 1924

17

I HEREBY CERTIFY, That I attended deceased from ..... 1922, to Nov. 19 1924, that I last saw h— alive on Nov. 17 1924, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Angina Heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hauff, M. D.

, 19 (Address) 1543 N Gallo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Nov 21 19 24

20 UNDERTAKER: Joseph B Cook ADDRESS: 1003 N Gallo St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92177

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St Joseph's Hosp. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma V. Bromwell

(a) Residence No. 2300 Garrison Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced ~~Husband~~ of (or) WIFE of Richard E. Bromwell

6-DATE OF BIRTH (month, day and year) Sept. 24, 1850

7-AGE. 74 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Carroll Co Md

PARENTS.

10-NAME OF FATHER. John Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Leah Burkhardt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carroll Co Md

14- (Informant) Richard E. Bromwell

(Address) 2300 Garrison Ave

15-

Filed ... Robert P. Harrison ... Registrar.

NOV 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 20-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1924 to Nov 20 1924

that I last saw her alive on Nov. 20 1924

and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma sigmoid colon

Intestinal Obstruction

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 2300 Garrison Ave

Did an operation precede death? Yes Date of Colostomy Nov. 13, 1924

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) Geo Englehart M. D.

NOV 21 1924

(Address) St Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL. ~~CREMATION, OR REMOVAL.~~ London Park DATE OF BURIAL. NOV 22 1924, 19

20-UNDERTAKER. Geo W Little ADDRESS 2700 EDMONDSON AVE.

NOV 20 1924

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92178

HEALTH DEPARTMENT—CITY OF BALTIMORE

1D 92178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3629 Old York Road, 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Edmund Graham Jones

(a) Residence No. 3629 Old York Road St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE~~ of Gladys D. Jones

6-DATE OF BIRTH (month, day and year) Oct. 22, 1899

7-AGE, 25 yrs. - mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Oil

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Jones

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary Kane

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore Md

14- (Informant) Gladys Dulin Jones

(Address) 3629 Old York Road

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 20 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) NOV 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924, to Nov 19, 1924, that I last saw him alive on Nov 17, 1924, and that death occurred, on the date stated above, at 9-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. - mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edmund Truby, M. D.

(Address) 3672 Greenmount Ave

NOV 20 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, NOV 21 1924

20-UNDERTAKER, Geo W Little ADDRESS, EDMONDSON AVE.

NOV 20 1924

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 92179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. ..... WARD)

2-FULL NAME Geo Dunnaway

(a) RESIDENCE NO 285-H-31 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Dunnaway

6 DATE OF BIRTH (month, day, and year) July 14 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer United Railway

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary L Dunnaway
(Address)

15 Filed NOV 20 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Jumped from Balcony 7th Floor

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. 4 ds.

(Signed) Geo E. Beals, M. D.
(Coroner)
Nov 20, 192 (Address) 123 E Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrys Point Va	Nov 21 1924
20 UNDERTAKER	ADDRESS
Schenowsky & Son	1617 Eutaw

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 20 1924

Portal Funeral Home

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92180

CERTIFICATE OF DEATH.

40 D 92180

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 E. Perry ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~126 W. Pra~~ Benj. Hand

(a) RESIDENCE No 126 E. Perry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Said 71 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Medicine Seller
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mary Shultz
(Address) 126 E. Perry St

15 Filed NOV 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv dis. Lear V

Ven Sect (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Dropsy (duration) yrs. mos. ds.

(Signed) W. Paley, M. D. (Coroner.)

Nov. 20 192 4 (Address) 1037 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Nov 22 192 4
20 UNDERTAKER Wm. Brown's Son	ADDRESS 1437 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-31—E.B.R.S.—400 Bks.

D 92181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92181

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 925 Leadenhall St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Octavia Singleton

(a) Residence No. 925 Leadenhall St., 23 Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Singleton

6-DATE OF BIRTH (month, day and year) Aug 26 1900

7-AGE. 24 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), N.C.

PARENTS.

10-NAME OF FATHER, Brooks Bonnell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N.C.

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N.C.

14-

(Informant) Paul Singleton

(Address) 925 Leadenhall St

15-

Filed NOV 21 1924 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/19/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 19 24 to Nov 19 19 24

that I last saw h... alive on Nov 18th 19 24

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

Chronic (Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Recurrent

Bronchitis (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

11/19, 19 24 (Address) 908 Druid Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mt Hope	Nov 21, 1924
20-UNDERTAKER.	ADDRESS
Robt Brown & Son	1820 Madison Ave

N. B.—WHITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Terms, such as "Cancer," "Consumption," "Paralysis," "Dropsy," "Fever," "Old Age," "Infantile," should be carefully supplied. AGE should be stated EXACTLY. Unknown or indefinite statements will not be accepted. Cause of death must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92132

CERTIFICATE OF DEATH.

D 92132

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 Markley Ave Lauraville St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clifton Heuse

(a) Residence No. 19 Markley Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Martha Heuse

6-DATE OF BIRTH (month, day and year) Dec 28, 1871

7-AGE. 52 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Floor Manager

(b) General nature of Industry, business, or establishment in which employed (or employer). Stewart Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, August Heuse

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Alice Clifton

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Martha Heuse

(Address) 19 Markley Ave

15- Filed NOV 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 18. 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to Nov 18 1924

that I last saw h.. alive on Nov 18 1924

and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Cardiac Decompensation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Jones M. D.

11/18. 1924 (Address) 706 Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cem.	Nov. 21. 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1210 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92183

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Josephs Hosp St. (Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hildegarde Queen

(a) Residence No. Rossville Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 21 1922

7-AGE. 2 yrs. — mos. — ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Non

(b) General nature of Industry, business, or establishment in which employed (or employer) Non

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lemore Run Balt Co

PARENTS

10-NAME OF FATHER, Harry Queen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Marian Russell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt Co

14- (Informant) Mother Marian Queen

(Address) Back River Neck Balto

15- Filed NOV 21 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8, 19 24 to Nov. 14, 19 24

that I last saw h.. alive on Nov. 19, 19 24

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lacerated Scalp wound

(Duration) yrs. mos. 17 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Chem. & Clin. test

(Signed) Leo P. Gilbert M. D.

, 19 (Address) St. Josephs Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Gravel Run Cem — DATE OF BURIAL, NOV 21 1924

20-UNDERTAKER, Mrs R A Elliott — ADDRESS 1725 Oakland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Rachael Kirshenbaum

D 92184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92184

CERTIFICATE OF DEATH.

13 73

1-PLACE OF DEATH

City of BALTIMORE: (No. 940 Brooks Lane St., 13 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rachael Kirshenbaum

940 Brooks Lane

(a) Residence No. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Kirshenbaum

6-DATE OF BIRTH (month, day and year) 1857

7-AGE.	If LESS than 1 day,
67 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 67

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Morris Kirshenbaum

(Address) 940 Brooks Lane

15- Filed NOV 21 1924 ROBERT B. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1924 to Nov 20 1924

that I last saw h~~e~~r alive on Nov 19 1924

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

Cerebral Embolism

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical S

(Signed) C. Hirschmann M. D.

. 19 (Address) 877 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Hebrew Washington Blvd	11/21 19 24

20-UNDERTAKER.	ADDRESS
Jack Levin	1429 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92185

D 92185

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 15 ST., WARD)

2-FULL NAME Mr. Isadore Rachlin

(a) RESIDENCE NO. 2408 Baker St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Rachlin

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cap Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 042

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eldadox

15 Filed , 19 ROBERT R. KRAUTER, Registrar

Burial Permit

NOV 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1924, to Nov 20, 1924, that I last saw him alive on Nov 20, 1924 and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypernephroma, right kidney.

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/20/24

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Walter Goldsmith M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hortmen Circle Cem DATE OF BURIAL 11/21 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eldadox

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92186

CERTIFICATE OF DEATH.

D 92186

REGISTERED NO. 137

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 10 WARD)

2-FULL NAME Mrs Anne Eisenstein

(a) RESIDENCE NO. 1040 L. Monument ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Eisenstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or mnts.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) (37)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Elhudi Legma.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Chera

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto street

15 Filed NOV 21 1924 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/7/24, 1924, to 11/21/24, 1924, that I last saw her alive on 11/21/24, 1924, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Ovarian cyst. Thyrotoxicosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/19/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Philip Garrison, M. D.

, 19 (Address) Hebrew Agcy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 11/21 1924

20 UNDERTAKER Jack Lewis 1439 E Balto st

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92187 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D 92187

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 612 N. Carrollton Av 16 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stafford

(a) Residence No. Aged Mens Home St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT COMPLETELY AND LEGIBLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 17, 1852

7-AGE, 72 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore

(State or Country)..... Md

PARENTS.

10-NAME OF FATHER, James Stafford

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), England

12-MAIDEN NAME OF MOTHER, Mary M. Dorrel

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), America

14- (Informant) Mrs Lola C. Fisher

(Address) 1400 W. Lexington St

15- Filed ..... 19.. ROBERT R. KRAUTER Burial Permit Clerk

NOV 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Nov 20, 1924

that I last saw him alive on Nov 20, 1924

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ..... yrs. ..... mos. 30 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Mitchell M. D.

11/21, 1924 (Address) 108 N. Bulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mount Olivet	Nov 22, 1924
20-UNDERTAKER, George J. Smith	ADDRESS 532 Hollins St

Spec.—1-10-21 M&T 1500 Bks.

D 92188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92188

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 Ellsworth ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Grain

(a) RESIDENCE NO. 2039 Ellsworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	17	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Straw hat

(b) General nature of industry, business, or establishment in which employed (or employer) Trimmer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Edwin. E. Grain Sr

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Appel

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mr. Edwin. E Grain Jr.

(Address) 1019 Rockland ave

15 Filed NOV 21 1924 VICENT B. KRUSEN, Registrar

Burial Permit Clerk

Stan

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1924, to Nov 20 1924,

that I last saw h... alive on ....., 19...,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurg + Aortic Stenosis

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interst. Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of "

Was there an autopsy? No

What test confirmed diagnosis? "

(Signed) August Stony M. D.

, 19 (Address) 2808 Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 22 1924
20 UNDERTAKER	**ADDRESS**
Henry Hardt Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 D 92189

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Johnson

(a) RESIDENCE NO. 2139 E. Biddle St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) March 13, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Daisy Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records (Address) Johns Hopkins Hospital

15 NOV 21 1924 RUDOLF R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 25. 1924. to Nov 19. 1924.

that I last saw her alive on Nov. 19 1924.

and that death occurred, on the date stated above, at 6 20 A. m.

The CAUSE OF DEATH* was as follows:

Acute generalized miliary tuberculosis

(duration) yrs. 2 mos ? ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) yrs. 1 mos. + ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 27, 1924

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund N. Kerper, M. D.

11/19. 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 22 1924
20 UNDERTAKER J. J. Moran	ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92190

CERTIFICATE OF DEATH.

D 92190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. On way to Mercy Hosp. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Bishop.

(a) RESIDENCE NO Magnolia Ma- ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4 y	about 1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck walker
(b) General nature of industry, business, or establishment in which employed (or employer) 073
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant David Davidson.
(Address) Sollers Md.

15 Filed ... 192 ... HOWARD H. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries Caused from pressure
Shock.
Fract. both
Struck by R. R. Engine (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) H. C. Ashley, Jr., M. D.
(Coroner.)
June 21, 192 4 (Address) 1654 Etting

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. State ... yrs., ... mos., ... ds. In the City Remainder 2 hours

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sollers Md. DATE OF BURIAL 11-21 1923

20 UNDERTAKER E. B. Hale ADDRESS 115 E. Hoffman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-12-23-21-E.B.R.S.-400 Bks.

D 92191 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92191

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 2516 Madison Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Greenthal

(a) Residence No. 2516 Madison ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widow, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Greenthal

6-DATE OF BIRTH (month, day and year) Unk

7-AGE. 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS:
10-NAME OF FATHER, Jack Schrogo
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14-(Informant) Jake Greenthal
(Address) 2516 Madison ave

15-Filed NOV 1 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-21-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 19 24 to Nov 18 19 24 that I last saw h. alive on Nov 18 19 24 and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan Helfgott M. D.
19 (Address) 17 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Rebers Wash Road — DATE OF BURIAL. 11-[illegible]-24

20-UNDERTAKER, [illegible] Lewis — ADDRESS 1897 E. Balti

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92192 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92192

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P. Woods

(a) RESIDENCE No. 1608 E. Hoffman st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1882 Dec 9

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McGraw

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed NOV 21 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1924, to Nov. 19, 1924, that I last saw him alive on Nov. 19, 1924, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) J. T. White, M. D.

11-19-24 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemty	Nov 23 1924

20 UNDERTAKER Robt J Turner & Son ADDRESS 1402 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92193 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92193

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 Forrest ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie May Wilson Kimbel

(a) RESIDENCE NO. 317 Forrest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Alabama
(State or country)

PARENTS

10 NAME OF FATHER Jas Kimbel

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mary V. Wilson
(Address) 317 Forrest

NOV 21 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

Name

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

3 mos. from history of case
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Nov 19, 1924 (Address) 1639 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov. 21 1924
20 UNDERTAKER	ADDRESS
Chas. F. Johnson	[illegible]

IMPORTANT—AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92194

D 92194 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-001

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd + Calvert ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tracy Biggs

(a) RESIDENCE NO. 2143 Penrose Ave ST., WARD city

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Elmer Biggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) maryland

12 MAIDEN NAME OF MOTHER Katherine Barney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) maryland

14 Informant Elmer Biggs

(Address) 2143 Penrose Ave

15 NOV 21 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

H.A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924, to Nov 20, 1924, that I last saw him alive on Nov 20, 1924 and that death occurred, on the date stated above, at 5 46 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ,

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? X Ray -

(Signed) C.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov. 22 1924
20 UNDERTAKER	ADDRESS
Geo. Schwab	210 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X101,001

D 92195

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cendrew Bergen Merlin

(a) RESIDENCE NO. 114th 27th ST., WARD Gutenberg, N.J.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Trainer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West New York New Jersey

PARENTS

10 NAME OF FATHER Henry Merlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria Bergen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) University Hospital

15 Filed NOV 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1924, to Nov 21, 1924, that I last saw him alive on Nov. 21, 1924, and that death occurred, on the date stated above, at 6.35 a.m.

The CAUSE OF DEATH* was as follows:

(1) Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Anderson, M. D.

, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jersey City N.J. DATE OF BURIAL Nov 24 1924

20 UNDERTAKER Harry V. Witzig ADDRESS 1531 W. Lom

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92196

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

D 92196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 610 N. Potomac St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Tyler

(a) Residence No. 610 N. Potomac St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Donzella Tyler

6-DATE OF BIRTH (month, day and year) Feb 18 81

7-AGE. 43 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Internal Rev

(b) General nature of industry, business, or establishment in which employed (or employer) Revenue Dept.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Somerset Co Md

PARENTS.

10-NAME OF FATHER, Robt E. Tyler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Amanda S. Hall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Donzella Tyler

(Address) 610 N. Potomac St

15- NOV 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/20/24

I HEREBY CERTIFY, That I attended deceased from Nov. 19 1924 to Nov. 20 1924

that I last saw h~~im~~ alive on Nov. 20 1924

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Ulcer of stomach.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hardening

(Duration) ....yrs. ....mos. 1 ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Wm J. Schmit M. D

Nov 24 1924 (Address) 701 N. Howard Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	11/22 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92197

105 D 92197

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Paul Connell

(a) RESIDENCE NO. Mercy Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Va.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Connell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Donovan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records
(Address)

15 NOV 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20/1924

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to Nov. 20, 1924 that I last saw her alive on 11/20/24, 19 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery (Mt. Washington) DATE OF BURIAL: Nov 22nd 24

20 UNDERTAKER: Henry Hendrix & Son ADDRESS: Eldwood Pa-Collegeville

Spec.—1-10-21—M&T—1500 Bks.

D 92198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

REGISTERED NO. D 92198

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard · Green EGEBERG ST., 16 WARD)

2-FULL NAME Mr. Albert Egeberg.

(a) RESIDENCE NO. 305 Baltimore Av. St Helena ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~Widow of~~ Alice M Egeberg

6 DATE OF BIRTH (month, day, and year) Feb 18 1863

7 AGE: Years 61 | Months 9 | Days 2 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician for B & O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Alice M Egeberg
(Address) 305 Baltimore Ave St Helena

15 Filed NOV 21 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/24 19

17

I HEREBY CERTIFY, That I attended deceased from 11/13 . 1924, to 11/19 . 1924.

that I last saw him alive on 11/19 . 1924,

and that death occurred, on the date stated above, at 3 P . m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/14/24

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) M. Edwards. M. D.

, 19 (Address) University Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Nov 22 1924

20 UNDERTAKER John F Denny — ADDRESS 755 Lex

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92199

CERTIFICATE OF DEATH.

113 D 92199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1252 Sargeant St ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy ~~Dorothy~~ Bridges

(a) RESIDENCE NO. 1252 Sargeant St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: -

6 DATE OF BIRTH (month, day, and year) Aug 30-1924

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Herman Bridges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Annie Neader

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant Annie Reader (Address) 1252 Sargeant St

15 Filed NOV 21 1924 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 19 24, to Nov. 21, 19 24, that I last saw him alive on Nov. 21, 19 24, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edward J. Sensabaugh, M. D.

, 19 (Address) 24 W Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity — DATE OF BURIAL: Nov 22 1924

20 UNDERTAKER: John Fields 1200 W Fayette — ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Funk

D 92200 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

90 Cer Hour ✓

CERTIFICATE OF DEATH.

D 92200

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 12th Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Funk.

(a) RESIDENCE No. 1541 Clifton av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Funk

6 DATE OF BIRTH (month, day, and year) July 17th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor
(b) General nature of Industry, business, or establishment in which employed (or employer) B & O R R
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Frederick Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Tilla Dupin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Mrs. Funk
(Address) 1541 Clifton Av

15 Filed NOV 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an M Quest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said M Quest (Inquest, autopsy or inquiry.) find that said deceased came to Acc death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
post Ven dis bl
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Fuller, M. D.
(Coroner.)
Nov 21 1924 (Address) 4139 Ins

*State the Disease Causing Death, as in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Frederick	Nov 23 1924
20 UNDERTAKER	ADDRESS
John Fields	120 N Eutaw

MAKE ENTRIES WITH INK OR TYPEWRITER. PHYSICIANS SHOULD BE VERY EXACT. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92201

CERTIFICATE OF DEATH.

D 92201

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2815 Orland ave ST., 27 WARD)

2-FULL NAME Elizabeth Louise Spamer.

(a) RESIDENCE NO. 2815 Orland ave ST., ... WARD ..

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov 7th 1885

7 AGE. Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public School Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer) Social Welfare Worker

(c) Name of employer Balto City Mod

9 BIRTHPLACE (city or town) (State or country) New London Connecticut

PARENTS

10 NAME OF FATHER Adolph Spamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Frances A Thum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Adolph Spamer (Address) 2815 Orland ave

15 NOV 21 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15- 1923 to Nov. 20- 1924.

that I last saw her alive on Nov. 19- 1924.

and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of breast.

(duration) 1 yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Nov. 1919.

Was there an autopsy? no. Jan. 10. 1924

What test confirmed diagnosis? Microscopical.

(Signed) J. Bard Bisher M. D.

Nov. 21 1924 (Address) 1125 Mayfair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	11/22/1924

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Cor.—1-12-23—M&T—100 Blks.

D 92202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92202

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 134 W Baal ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Deborah Forsythe

(a) RESIDENCE NO 248 E. Hamburg ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Forsythe

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	74	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant F. A. Krause
(Address) 203 Hanover st

15 Filed NOV 21 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

(Signed) W. S. Q. Riley (Coroner.) M. D.

Nov 19, 192X (Address) 100 S. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Brooklyn Md	Nov 21 1924
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	203 Hanover

AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S. A. E. T. Y.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 92203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92203

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 219 Tramore Road Ham. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sophia A. Forrester

(a) Residence No. 219 Tramore Road Ham. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Forrester

6-DATE OF BIRTH (month, day and year) Nov. 21 1842

7-AGE.	If LESS than 1 day,
81 yrs. 11 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm. G. Durhurst

11-BIRTHPLACE OF FATHER (city or town)..... Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).... Unknown
(State or Country),

11-

(Informant)..... Mrs. Deeter

(Address)..... 219 Tramore Road

15-

Filed..... Robert P. Harrison, ...
Registrar.

NOV 21 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). NOV. 19-1924

17- I HEREBY CERTIFY, That I attended deceased from May ..... 1924 to Nov 19 ..... 1924.

That I last saw her alive on Nov 19 1924,

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma - (bladder) (cerv.)

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY
(Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) J. D. Kimzey M. D.

11; 20, 1924 (Address) 2700 Harford Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	11/22, 19.24
20-UNDERTAKER.	ADDRESS
J. Fred McCully	1308 E. Fort

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD and should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

OO DAK K

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92204

CERTIFICATE OF DEATH.

Registered No. 4 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 1707 Byrd St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Burgess

(a) Residence No. 1707 Byrd St., 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND (~~of~~) ~~WIFE~~ of Barbara Burgess

6-DATE OF BIRTH (month, day and year) April 19, 1875

7-AGE. 29 yrs. 7 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) helper 806

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Burgess

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Barbara Burgess

(Address) 1707 Byrd St

15- Filed NOV 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from July, 1922, to Nov. 20, 1924

that I last saw h[illegible] alive on Nov. 7, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary Chronic

about 2 yrs. 6 mos. ds. (Duration)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) W. H. Tippett, M. D.

, 19 (Address) 132 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, National Cemetery DATE OF BURIAL, Nov. 23, 1924

20-UNDERTAKER. ADDRESS

A. Howard Evans 38 E. Fort Ave

WHITE—PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92205

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Bay View Hospital Registered No.....

City of BALTIMORE: (No.....St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Smith

(a) Residence No. 1168 N. Calhoun St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Delaphine Smith

6-DATE OF BIRTH (month, day and year) 1882.

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do. Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do. Do.

11- (Informant) Bay View Hospital

(Address) Balto, Md.

15- Filed Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 19-24

17- I HEREBY CERTIFY, That I attended deceased from Mar 30, 1923 to Nov 19, 1924 that I last saw him alive on Nov 19, 1924 and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & pathological

(Signed) W. J. Ashcraft M. D.

, 19 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL, Nov. 22, 1924

20-UNDERTAKER, Virginia A. Brooks — ADDRESS 1463 N. Carey St

Burial Permit Clerk.

NV2 T1084

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANSWERS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 92206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92206

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Church Home & Infirmary W 57

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Kerr.

(a) Residence No. 2213 N. Charles St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Edward Kerr

6-DATE OF BIRTH (month, day and year) ? 1850

7-AGE. 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Matthew Healy

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Mary Cunningham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Hospital Record

(Address)

15- Filed Nov 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1924 to Nov. 19 1924

that I last saw h~~e~~r alive on Nov. 19 1924

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

~~Intestinal Obstruction~~

Hernia, postoperative, ventral

strangulated —

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes & Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Heinrich C. Rieck — M. D

19 (Address) Church Home & Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem. DATE OF BURIAL. 11/23 1924

20-UNDERTAKER. Forrest Funeral Parlor ADDRESS Fulton & Laydon

NOV 21 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92207

D 92207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 W Baltimore St., 17 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andy Thomas Floyd

(a) RESIDENCE No. 610 W Baltimore St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred (yrs. 34) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 30 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Goodyear Rubber Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Rachel Floyd Mother

(Address) 914 Elm Place

15 Filed ....., 19.....

Robert F. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov-18, 1924, to Nov 19, 1924.

that I last saw h.... alive on Nov 18, 1924

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R B Tennyson, M. D.

11/19, 1924 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 23 1924

20 UNDERTAKER W. M. Johnson

ADDRESS 309 Druid Hill Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 21 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92208 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 18 | 29

City of BALTIMORE: (No. 1621-W-Lexington St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Anderson

(a) Residence No. 1621-W-Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 2 mos. 7 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE, 60 yrs. 9 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress 04

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Anne E. Borrowson

(Address) 1827-Ursine St

15- Filed NOV 21 1924, 19?? Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-19-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 18, 19 24, to Nov 19, 19 24,

that I last saw h[illegible] alive on Nov 18, 19 24,

and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis

(Duration) ? yrs. ? mos. ? ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Wallace J. Gibson, M. D.

, 19 (Address) 1618-W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem. — DATE OF BURIAL, 11-22-24

20-UNDERTAKER Edward Carton — ADDRESS 916 Lanvale

GEN. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92209 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92209

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 615 Watts Ct St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rena Bowman

(a) Residence No. 615 Watts Ct St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Jas. Bowman

6-DATE OF BIRTH (month, day and year) Dec. 20 1885

7-AGE, 38 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Cabarrus

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cabarrus

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Cabarrus

14- (Informant) W. H. Bowman

(Address) 615 Watts Ct

15- Filed NOV 21 1924, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-20-24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 1924 to Nov. 20 1924

That I last saw h[illegible] alive on Nov. 20 1924

and that death occurred, on the date stated above, at 3.03 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

11/21 1924 (Signed) Frank E. Wagner M. D.

(Address) 1006 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt Auburn Cem	11-22-24
20-UNDERTAKER.	ADDRESS
Dan'l Cotton	916 Penna Ave

A. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—I-12-23—M&T—100 Bks.

D 92210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92210

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Brittmert

CITY OF BALTIMORE: (No. 1215 Brierwate ave ST., 25 WARD)

REGISTERED NO. 74-000

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paulena L Fischbach

(a) RESIDENCE No. 2140 Market ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Fischbach

6 DATE OF BIRTH (month, day, and year) March 9th 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Fischbach (Address) 2140 Market St

15 Filed NOV 21 1924, 192 Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to Her death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

a Week

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Yes (duration) Yrs mos. ds.

(Signed) Geo. D. Horton, M. D. (Coroner)

Nov 20. 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetry	Nov. 22, 1924
20 UNDERTAKER Tom Cook	ADDRESS 502 E Hoffe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 92211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00 D 92211

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 d Paca ST. 21 WARD)

2-FULL NAME William H. Kahlway.

(a) RESIDENCE. No. 808 d Paca. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Wht	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Josephine Kahlway.

6 DATE OF BIRTH (month, day, and year) Sept 24-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga. Va. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lydia Dierszen

(Address) 808 d Paca St.

15 Filed NOV 1 1924, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924, to Nov 19, 1924, that I last saw h— alive on Nov 18, 1924, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Crumplen, M. D.

11/20 1924 (Address) 517 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	Nov 22, 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E. Fayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

Spec. 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92212

D 92212

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 75 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen Jennings

(a) Residence No. Lansdowne Md St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word): married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank D Jennings

6-DATE OF BIRTH (month, day and year): Sept 9 1875

If LESS than 1 day, ...hrs. or.... min.

7-AGE: 49 yrs. 2 mos. 1 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS

10-NAME OF FATHER: Do not Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Do not Know

12-MAIDEN NAME OF MOTHER: Do not Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Do not Know Md.

14- (Informant) Frank D Jennings Husband.

(Address) Lansdowne Md

15- Robert P. Harrison, Registrar.

Filed NOV 21 1924 192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 24-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 27th 1924 to Nov 20th 1924 that I last saw h[illegible] alive on Nov 20th 1924 and that death occurred, on the date stated above, at 3.50 p m. The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Bilateral Pneumonia

(Duration) ... yrs. ... mos. 2 wks

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/28/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J Thos B. E. Deegan M. D.

(Address) 904 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 24 1924

20-UNDERTAKER: Edw Cook Co — ADDRESS: Eutaw & Lanvale

N. B.—WRITE PLAINLY, WITH PEN AND INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See should be carefully supplied, so that it may be properly classified. Entries should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-24—M&T—1500 Blks.

D 1069

D 92213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gracey

(a) RESIDENCE No. Clarksburg W Va ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate —

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 59 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: — 131

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER: James Gracey

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Martha Nicholas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 NOV 21 1924 Robert P. Harrison, Registrar

Burial Permit Oked

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 - 1924 to Nov 20 1924.

that I last saw him alive on Nov 20 1924,

and that death occurred, on the date stated above, at 8 1/2 P m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma of Mediastinum & gland involvement.

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Perforated diverticulum of ampulla of Vater (duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Removal of gland 10 days prior. Date of Nov. 10, 1924

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Louis E. Martin M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Clarksburg W. Va — DATE OF BURIAL: Nov. 21 1924

20 UNDERTAKER: William G. Schaffer — ADDRESS: 1816 Hanover

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 92214 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 N.Caroline St St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Curtis Bennett Simonds

(a) Residence No. 1308 N.Caroline St St., Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? 79 yrs. 11 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Simonds

6-DATE OF BIRTH (month, day and year): Jan-4-1845

7-AGE: 79 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore
(State or Country): Md.

PARENTS.

10-NAME OF FATHER: Levi Simonds

11-BIRTHPLACE OF FATHER (city or town): ?????
(State or Country): Mass.

12-MAIDEN NAME OF MOTHER: Koranda Bennett

13-BIRTHPLACE OF MOTHER (city or town): Baltimore Co.
(State or Country).

14-
(Informant): Miss Anna A Simonds (Daughter)
(Address): 1308 N.Caroline St

15-
Filed ..... 192.
Robert P. Harrison, Registrar.

1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov-20-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923 to Nov 20, 1924
that I last saw h. alive on Nov 20, 1924
and that death occurred, on the date stated above, at 5-7 p. m.
The CAUSE OF DEATH* was as follows:

Senile Dementia
Sclerosis of cerebral arteries

(Duration) 32 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Coma

(Duration) yrs. mos. 24 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. W. Edwards, M. D.

Nov 24 1924 (Address) 1226 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL, Nov. 22/ 1924

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

WHITE PENCIL, WITH UNDERLINE, should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William V. Boyle Chew

(a) RESIDENCE NO. 1000 E. Monument ST., ... WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? 57 yrs. 8 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Ruffel Chew

6 DATE OF BIRTH (month, day, and year): Feby-22-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	57	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.

(c) Name of employer: B & O

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: William B. Chew

11 BIRTHPLACE OF FATHER (city or town) (State or country): P.G. Co. Maryland

12 MAIDEN NAME OF MOTHER: Helen Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs. J. Chew (Son)

(Address): 2736 W. Baltimore St.

15 Filed ..... 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16. 1924. to Nov. 20. 1924

that I last saw him alive on Nov. 20. 1924.

and that death occurred, on the date stated above, at 1245 AM.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Insanitum

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Nov. 19 - 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L. Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Nov 22 1924

20 UNDERTAKER: STEWART & HOWEN COMPANY (WILLIAM F. HOWEN, Successor)

ADDRESS: 108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92216

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 813 Beaumont Ave St. 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Sarah J. Pippen

(a) Residence No. 813 Beaumont Av St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.)

5a-If married, ~~widowed, or divorced~~ (or) WIFE of William V Pippen

6-DATE OF BIRTH (month, day and year) Sept 21 1862

7-AGE, 62 yrs. 2 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John C Luthes

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Rosanna Hanna

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore Md

14-(Informant)..... Wm V Pippen

(Address)..... 813 Beaumont Av

15-Filed NOV 22 1924, 19.... Robert P. Harrison, Registrar. ~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

NOV 21 1924

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from January 1924, to November 21 1924, that I last saw h.r alive on November 20 1924, and that death occurred, on the date stated above, at 10 12 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 62 mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? yes (Examination)

(Signed) A. K. A Meyer, M. D.

NOV 22 1924, 19 (Address) 2438 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL. Loudon Park — DATE OF BURIAL, NOV 24 1924, 19....

20-UNDERTAKER, Geo W Settle — ADDRESS 2700 EDMONDSON AVE

WRITE PLAINLY, with UNFADING INK. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. See instructions on back of certificates.

NOV 22 1924

Spec—12-23-21—E.B.R.S.—400 Blks.

Dua.

D 92217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward) 73

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary Dua

(a) Residence No. 401 S. High St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1856

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown?

12-MAIDEN NAME OF MOTHER, Unknown?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown?

14-

(Informant) Municipal Hospital Records

(Address)

15-

FILED ..... 192 .....

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-20-24

17- I HEREBY CERTIFY, That I attended deceased from 10-16, 1924, to 11-20, 1924, that I last saw h[illegible] alive on 11-20, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Senile Retrogression;

Paralysis Agitans

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Claude C. Dow, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St Vincent	Nov 22, 1924
20-UNDERTAKER,	ADDRESS
Wendell Bippel & Son	378 Penna

NOV 22 1924

WHITE PAPER, WITH PRINTING IN BLACK INK ONLY. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

92218

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-901 D 92218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 604 S. Fulton Ave St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C Williams

(a) Residence No. 604 S Fulton Ave St., Ward.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mar 1st 1918

6-DATE OF BIRTH (month, day and year) Mar 1-1918

7-AGE. 6 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer). none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Chas. E Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mollie Cook

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-

(Informant) Chas E Williams

(Address) 604 S Fulton Ave

15-

Filed ROBERT P. HARRISON, Registrar.

V2 21924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-20-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1924 to Nov 20 1924

that I last saw him alive on Nov 20 1924

and that death occurred, on the date stated above, at 7:30 PM.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible] M. D

11/24 1924 (Address) 2406 Garrison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Western Cem	11—22 1924
20-UNDERTAKER, Robert Brooks & Son	ADDRESS Calhoun Hollins sts

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92219

CERTIFICATE OF DEATH.

23 113

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 935 Hanover St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Wayson

(a) Residence No. 935 Hanover St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 23 1924

7-AGE. ..... yrs. 8 mos. 28 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of indnstry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Md. (State or Country),

PARENTS.

10-NAME OF FATHER, John H. Wayson

11-BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Florence Henning

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or Country),

14-

(Informant) Mrs. Wayson

(Address) 935 Hanover St.

NOV 22 1924

Filed ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 21-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 19 24 to Nov 21 19 24

that I last saw him alive on Nov 21 19 24

and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Uraemia Calculi

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Campbell M. D.

Nov 21, 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Johns Cem. Annapolis Md.	11 24 1924

20-UNDERTAKER. J. Fen McCarthy

ADDRESS 130 e. Fort

WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92220 D 92220

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3003 Ellerslie Ave ST., 9 WARD)

2-FULL NAME John T Yeager

(a) RESIDENCE NO. 3003 Ellerslie Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella C Yeager

6 DATE OF BIRTH (month, day, and year) May 30 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	76	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General Labor

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Yeager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) N. 13 Grafton 3003 Ellerslie Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

OV 2 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1924

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1924, to November 20, 1924, that I last saw him alive on November 20, 1924, and that death occurred, on the date stated above, at 1:20 p m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) 0 yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Eugene Huthsteiner, M. D.

Nov 29 1924 (Address) 1615 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Nov 21 1924

20 UNDERTAKER W. M. Cook ADDRESS 502 E Fayette

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Wm Boyd 29th & Barclay

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92221

CERTIFICATE OF DEATH.

129 D 92221

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 446 Lorraine Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Rafferty

(a) RESIDENCE NO. 446 Lorraine Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Rafferty

6 DATE OF BIRTH (month, day, and year): Oct 15, 1859

7 AGE: Years 65 Months 1 Days 6 If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: United Railways

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Rafferty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Ella Rafferty

(Address): 446 Lorraine Ave

NOV 22 1924

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1924

17 I HEREBY CERTIFY, that I attended deceased from Nov 20th, 1924, to Nov 21st 1924.

that I last saw h alive on Nov 20th 1924

and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Contracted Kidneys

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) George [illegible] M D, M. D.

11/21/24 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Joseph's Texas Md

DATE OF BURIAL: Nov 24th

20 UNDERTAKER: William Cook

ADDRESS: Nov 24/24

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks. Elizabeth W. Richwien per Potter

D 92222

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-001

D 92222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2109 Atlantic Ave. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth W. Richwien

(a) RESIDENCE No 2109 Atlantic Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female		Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Richwien

6 DATE OF BIRTH (month, day, and year) Sept 15, 1859 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John W. Richwien
(Address) 2109 Atlantic Ave.

15 Filed NOV 22 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Potter, M. D.
(Coroner.)

11/21/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL , 192
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92223

D 92223

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Dyson

(a) RESIDENCE NO. 912 N. Caroline St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Elsie Brown
(Address) 912 N. Caroline Ave.

15 Filed NOV 22 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (autopsy) inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry) jury find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Staphicus Lymphaticus (Leukic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Nov. 20, 1924 (Address) 2502 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Nov 22 1924

20 UNDERTAKER Conrad Wahl Co — ADDRESS 873 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-24—M&T—1500 Blks.

1758 D 92224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92224

CERTIFICATE OF DEATH.

X 11-002

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 720 E. , ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Harrison

(a) RESIDENCE NO. 919 N. Ith Spallow St. WARD Stamford Point

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James T. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Viola Waggenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 22 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924 to Nov 21, 1924, that I last saw him alive on Nov 21, 1924, and that death occurred, on the date stated above, at 4 00 a.m.

The CAUSE OF DEATH* was as follows:

Influenza meningitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11/15/24

Was there an autopsy? Yes

What test confirmed diagnosis? Culture of organism from spinal fluid

(Signed) Edmund H. Kemper M. D.

11/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harriston Ga via Balto

DATE OF BURIAL Nov 22 1924

20 UNDERTAKER John F. Leary

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 22 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92225

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 830 S. Bond St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwika Andrychowska

(a) Residence No. 830 S. Bond St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 20-24

7-AGE. yrs. 5 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED —

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) — Wife

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Antoni Andrychowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Katie Wayka

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Katie Andrychowski

(Address) 830 S. Bond St

15- Robert P. Harrison,

Registrar.

NOV 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 21 8 am

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1924 to Nov. 21, 1924; that I last saw h[illegible] alive on Nov. 20, 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1. .....

Broncho Pneumonia

.....

.....

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P. S. E.

(Signed) John J. Kiger M. D.

, 19 (Address) 3627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL. Nov 22 1924

20-UNDERTAKER. F. W. Ozazeuski

ADDRESS. 1930 Eastern Ave

NOTE—WRITE PLAINLY, with unfading ink. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92226

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 16 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna V. Woodward

(a) Residence No. Church Home St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 13th 1833

7-AGE. 90 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Wm Woodward

11-BIRTHPLACE OF FATHER (city or town) (State or Country). A A Co Md

12-MAIDEN NAME OF MOTHER. V. Bernston

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

11- (Informant) Wm W Cloud

(Address) Yellow Cat Co

15- Filed ROBERT P. HARRISON, Registrar.

NOV 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 21st 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21 19 24 to Nov. 21 19 24

that I last saw h alive on Nov. 21 19 24

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Nil Date of

Was there an autopsy? Nil

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Henry U. S. Wilson M. D.

19 (Address) Church Home & Infr.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Greenmount Cem

DATE OF BURIAL. Nov 22 1924

20-UNDERTAKER. Henry H. Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts

U. S.—WHITE PLANET. WRITE ONLY WITH PEN AND INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92227

D 92227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 425 E. North Ave St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Lidie

(a) Residence No. 425 E. North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie E. Lidie

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 60 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Samuel Lidie

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Roberts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa.

14-(Informant) Mamie E. Lidie

(Address) 425 E. North Ave

15-

Filed NOV 22 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 21-1924

17- I HEREBY CERTIFY, That I attended deceased from March 2 1924 to Nov 21 1924

that I last saw him alive on Nov 20 1924

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

High Blood Pressure

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Heart Dilatation

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald T. Tonry M. D

Nov 21, 1924 (Address) 4142 North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	11/24 1924
20-UNDERTAKER.	ADDRESS
Chas. E. Krause Son	118 W. Mt. Royal Ave

NOTE—PHYSICIANS, NURSES AND OTHERS should state CAUSE OF DEATH EXACTLY. PHYSICIANS should state CAUSE OF DEATH. AGE should be stated EXACTLY, WHERE UNKNOWN, ESTIMATED AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92228

CERTIFICATE OF DEATH.

D 92228

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Otto K. Stewart (alice)

(a) RESIDENCE NO. Hornell, N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred y yrs. x mos. 6 ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE OF
Dr. Otto K. Stewart

6 DATE OF BIRTH (month, day, and year) April 2 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town)
(State or country) Canada

PARENTS

10 NAME OF FATHER Chas Valentine

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Alice Ireland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14

Informant Husband
(Address) Horwell, N.Y.

15

Filed Nov 24 1924, 19

Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924, to Nov 22, 1924, that I last saw h alive on Nov 22, 1924, and that death occurred, on the date stated above, at 1 20 a m.

The CAUSE OF DEATH* was as follows:

Glioma, left cerebral Hemisphere

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Horwell N.Y.

Did an operation precede death? yes Date of Nov 17-1924

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) P.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Horwell N. Y.	11/27, 1924

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W Mt Royal ave

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 92229 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 15164

City of BALTIMORE: (No. 1326 N. Caroline St., 15 Ward) (If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Malone

(a) Residence No. 1326 N. Caroline St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James Malone

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: about 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS:
10-NAME OF FATHER: Thos McCoy
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12-MAIDEN NAME OF MOTHER: Margaret Kelly
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-Informant: Mary J. Katzenberger
(Address): 1324 N. Caroline St.

15-Filed 19 Robert P. Harrison, Registrar.

NOV 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 20-1924

17- I HEREBY CERTIFY, That I attended deceased from 10-23 1924 to 11/20 1924 that I last saw h. Sr alive on 11/19 1924 and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lotts M. D

11/21 1924 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery | DATE OF BURIAL: Nov 24 1924

20-UNDERTAKER: Chas. P. Evans | ADDRESS: Nov 1180 W Royal ave

WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92230

100-901

D 92230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 Rutland Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos Ryan

(a) RESIDENCE NO. 1830 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick J Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant E J Casken

(Address) 1832 Rutland ave

15 NOV 22 1924, 19 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1924, to Nov 20, 1924

that I last saw h[illegible] alive on Nov 20, 1924

and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D W Bernardstein, M. D.

11/21, 1924 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 24 1924

UNDERTAKER E A Medefield Jr ADDRESS 501 E 23d

NOV 21 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92231 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No.) St. Joseph's Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Schmidt

(a) Residence No. 1317 E. Eager St., Ward.....
(Usual place of abode) (If non-residents give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Mary Schmidt

6-DATE OF BIRTH (month, day and year) July 29 1860

7-AGE. 64 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Ulrich Schmidt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

11-(Informant) Mrs. Wilhelmina Betz
(Address) 1315 E Eager St

15-
Filed Nov 22 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-21-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1924 to Nov. 21 1924
that I last saw h~~im~~ alive on Nov. 21 1924
and that death occurred, on the date stated above, at 9.40 a.m.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
Broncho pneumonia
(Duration) ....yrs. ....mos. 7 ds.
CONTRIBUTORY (Secondary) Carcinoma Stomach
(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? 1317 E. Eager St.
Did an operation precede death? No Date of.....
Was there an autopsy? No
What test confirmed diagnosis? Usual evidence
(Signed) Geo. B. Dyer M. D
(Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL, Nov. 24 1924

20-UNDERTAKER, Henry Hook Son — ADDRESS 1301 E Eager St

GEN. B—WRITE PLAINLY, WITH UNFADING INK. DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92232

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Hollins St ST., 18 WARD)

2-FULL NAME Emma G. Dimeler

(a) RESIDENCE NO. 1231 Hollins St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Dimeler

6 DATE OF BIRTH (month, day, and year) Unknown 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Swartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs Mary McGaughey 1231 Hollins St

15 Filed NOV 22 1924 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20/1924

17 I HEREBY CERTIFY, That I attended deceased from 11/17/, 1924, to 11/20, 1924,

that I last saw h[illegible] alive on 11/20/, 1924,

and that death occurred, on the date stated above, at 8 15 8 m.

The CAUSE OF DEATH* was as follows:

Chr D of Right

Cystitis & Ureteritis Double

& Goiter

(duration) 1 yr. mos da.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arnold Gray, M. D.

Nov. 21, 1924 (Address) 9 W. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Co. Cremation

DATE OF BURIAL Nov 24 1924

20 UNDERTAKER John F. Cowan & Son.

Asst. John F. Cowan

ADDRESS 301 Holliday St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92233

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert W. Lee

(a) Residence No. 515 S. Carolina St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1851

7-AGE. 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). 048

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) Municipal Hospital Records

(Address)

15-

Filed Robert P. Harrison, Registrar.

NOV 21 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-19-24

17- I HEREBY CERTIFY, That I attended deceased from 10-6, 1916, to 11-19, 1924 that I last saw h alive on 11-19, 1924 and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic

Myocarditis; Acute

Intoxication; Myocardial

Insufficiency (Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Claude A. Thomas, M. D.

11-20, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cem. DATE OF BURIAL. 11-22-1924

20-UNDERTAKER. Thomas A. J. Fink ADDRESS 1737 W. Pratt St.

WHITE CARDS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM

Spec.—1-10-21—M&T—1500 Bks.

HARDESTY

D. 92234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92234

CERTIFICATE OF DEATH.

× 40 D. 92234

D 92234

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Hardesty

(a) RESIDENCE NO. Emmittsburg, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 weeks How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emanuel Hardesty

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emanuel Hardesty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Eyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records. (Address)

15 NOV 22 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1X, 1924, to Nov 21, 1924,

that I last saw he alive on Nov 21, 1924,

and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Gonococcal Prostatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Winston M. M. D.

, 19 (Address) Union Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Harmony Md	Nov 24th, 24
20 UNDERTAKER H. H. Witzke	ADDRESS 1831 W Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 92234

S. A. E.

D A K

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92235

CERTIFICATE OF DEATH.

90 D 92235

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Penna Ave. ST., 14 WARD)

2-FULL NAME Harriett Carroll

(a) RESIDENCE NO. 1916 Penna Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of Thomas George Carroll

6 DATE OF BIRTH (month, day, and year) Feb. ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Giles

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Rachel Sheridan

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Maggie Gant
(Address) 1916 Penna Ave

15 Filed NOV 22 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-20 1924

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to Nov. 20, 1924.

that I last saw h.. alive on Nov 18, 1924,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Nelson Frey, M. D.

11/24, 1924 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL Nov 24th 1924

20 UNDERTAKER Byron & Wright

ADDRESS 1218 McElderry St

K—THIS IS A PERMANENT RECORD. Every ... of ... should be stated EXACTLY. PHYSICIANS sh... State it may be properly classified. Exact statement of OCCUPA... on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—T... mation should be carefully supplied. AGE sho... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See instructions on ba...

Spec- 12-23-2t—E.B.R.S.—400 Blks.

D 92236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92236

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 1644 E Monument St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mahala Cowsel

(a) Residence No. 1644 E Monument St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Calvin Cowsel

6-DATE OF BIRTH (month, day and year) unknown

7-AGE, Appox 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Nash Co N.C.

PARENTS.

10-NAME OF FATHER, Amos Whitley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N.C.

12-MAIDEN NAME OF MOTHER, Caroline Perry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N.C.

14- (Informant) Primo Cotton (Brother in law)

(Address) 815 - 1st Ave Portsmouth Va

15- Filed 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 22 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/22/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1923 to Nov 22 1924.

that I last saw h.. alive on Nov 21 1924.

and that death occurred, on the date stated above, at 3.06 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

11/22 1924 (Signed) R J Johnson M. D.

(Address) 1644 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Elm City N.C. DATE OF BURIAL, Nov. 21 1924

20-UNDERTAKER Mrs G. L. Locke ADDRESS 1302 Jefferson

(Printed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92237

CERTIFICATE OF DEATH.

D 92237

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 131 S. Fifth ST., 26 WARD)

2-FULL NAME John Reinhardt

(a) RESIDENCE NO. 131 S. Fifth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mall

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marg. Reinhardt

6 DATE OF BIRTH (month, day, and year): Oct. 23/1882

7 AGE: 42 (Years / Months / Days; If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer): 223

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Margaret Reinhardt 131 S. Fifth St.

15 NOV 22 1924 Robert M. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/21 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/1/23, 1923, to 11/21, 1924, that I last saw h[illegible] alive on 11/20, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Daniel L. Richman, M. D.

, 1924 (Address) 332 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov. 24, 1924

20 UNDERTAKER: John J. Berry & Son — ADDRESS: 1504 N. Luzerne

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92238

CERTIFICATE OF DEATH.

D 92238

+ 146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Bohm

(a) RESIDENCE No. Lexington Haven ST., Ca WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bohm

6 DATE OF BIRTH (month, day, and year) Aug 6-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Schuylkill Haven Pa

PARENTS

10 NAME OF FATHER Charles A Leibler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Schuylkill Haven Pa

12 MAIDEN NAME OF MOTHER Ida A Sherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Clair Pa

14 Informant (Address) Jack Levin 1439 Eutaw St

15 NOV 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1924, to Nov 22, 1924, that I last saw h e alive on Nov 22, 1924 and that death occurred, on the date stated above, at 3.10 m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection

(duration) ..... yrs. ..... mos. 2 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 22/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Philip Carlson, M. D.

. 19 (Address) Fremont Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schuylkill Haven Pa	11/25/24

20 UNDERTAKER ADDRESS

Jack Levin 1439 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92239

CERTIFICATE OF DEATH.

12 D 92239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 4 WARD)

2-FULL NAME Owen L. D Leason.

(a) RESIDENCE No. 8127 Harper Ave Chicago Ill.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chicago Ill.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hospital Record.
(Address)

15 Filed NOV 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/24

17 I HEREBY CERTIFY, That I attended deceased from 9/20/24, 19..., to 11/22/24, 19...,
that I last saw h— alive on 11/22/24, 19...,
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Hypertrophied Prostate
(Benign.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis Cardiac Decompensation ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of 11/15/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill. DATE OF BURIAL 11/28/24

20 UNDERTAKER Engell Faley Funeral Parlors ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92240

CERTIFICATE OF DEATH.

10

D 92240

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 Seventh st (Monell Park) St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES HENRY FULLER

(a) Residence No. 1001 Seventh st (Monell Park) St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 19. 1920

7-AGE. 4 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Vinson Fuller

11-BIRTHPLACE OF FATHER (city or town) Balto County (State or Country), Md

12-MAIDEN NAME OF MOTHER, Marietta Rotan

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) Mr. Vinson Fuller

(Address) 1001 Seventh st (Monell Park)

15- Filed NOV 23 1924 ROGER R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 22, 1924

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1924 to Nov 22 1924

that I last saw him alive on Nov 20 1924

and that death occurred, on the date stated above, at 1-15 P m.

The CAUSE OF DEATH* was as follows:

Diptheria

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. A. Kieffer M. D.

Nov 23 1924 (Address) 2320 Bond Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cemetery

DATE OF BURIAL. Nov 23, 1924

20-UNDERTAKER. Jos Joerdens + Son

ADDRESS 27 S. Paca st

N. B.—WRITE PLAINLY, with UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92241

CERTIFICATE OF DEATH.

D 92241

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3216 Westwood Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert B Ste Harry

(a) Residence No. 3216 Westwood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? 82 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widowed

5a-If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~late WIFE~~ of Ellen Ste Harry

6-DATE OF BIRTH (month, day and year) April 15 1841

7-AGE, 83 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Coach Painter

(b) General nature of industry, business, or establishment in which employed (or employer)..... 050

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, J. Wallace Ste Harry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah J Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-(Informant)..... Charles Ste Harry

(Address) 3216 Westwood Ave

15-Filed..... NOV 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) NOV 22 1924

17-I HEREBY CERTIFY, That I attended deceased from Nov. 7 19 24 to Nov 22 19 24

that I last saw h~~e~~r alive on Nov 20 19 24

and that death occurred, on the date stated above, at 1 P ~~A~~.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Geo Heuisler M. D.

NOV 22 1924 (Address) 300 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL, Mt Olivet — DATE OF BURIAL, NOV 24 1924, 19....

20-UNDERTAKER, Geo W Little — ADDRESS 2700 Edmondson Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92242

CERTIFICATE OF DEATH.

12 D 92242

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1712 Federal ST.: E 8 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Volk.

(a) RESIDENCE. No. 1712 Federal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Volk

6 DATE OF BIRTH (month, day, and year) Nov 15 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Turner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Volk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dortha Carl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Volk

(Address) 2226 E Lombard St

15 Filed ..... 19 14 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1924, to Nov 26, 1924

that I last saw him alive on Nov 24, 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) ..... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sandmann, M. D.

19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 24 1924
20 UNDERTAKER	ADDRESS
Kendall Dapple & Son	37 S Amity

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 92243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92243

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2309 Garrison Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carson Billingsley

(a) Residence No. 2309 Garrison Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Wallenhorst Billingsley

6-DATE OF BIRTH (month, day and year) Sept 6. 1881

7-AGE, 43 yrs. 2 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Real Estate agent 886

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Richard W. Billingsley

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER Annie Carson

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) Annie Carson Hutchins

(Address) 2309 Garrison Ave

15- NOV 23 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 21. 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1924 to Nov 21 1924

and that I last saw him alive on Nov. 21 1924,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Lober pneumonia

from History 6 days duration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lober pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter Tublett M. D.

Nov 24, 1924 (Address) 2220 Garrison ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemy. DATE OF BURIAL, Nov. 24, 1924

20-UNDERTAKER, John O. Mitchell ADDRESS 1201 W. Fayette St.

N. B.—WRITE PLAINLY, with unfading ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Albright

(a) RESIDENCE No. Granite Baltimore Co ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Porter Albright

6 DATE OF BIRTH (month, day, and year): July 21 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Not Employed.

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Woodstock Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Glenelg Md.

14 Informant: Hospital Records.

(Address)

15 Filed NOV 23 1924 19 ROBERT R. KRAMES Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22 nd. 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-18, 1924, to 11-22, 1924, that I last saw him alive on 11-22-, 1924, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Accident. Fell from Crutches fractured femur.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Renal Suppression

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 11-21-24

Was there an autopsy? no-

What test confirmed diagnosis?

(Signed) A. L. Anderson, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Granite Md.

DATE OF BURIAL: 11/24/24 19

20 UNDERTAKER: Harry A. Witzke

ADDRESS: 1531 W Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Hamilton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92245

CERTIFICATE OF DEATH.

6 + 11 ✓

D 92245

Registered No.....

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. Broadway & Fairmount St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Hamilton

(a) Residence No. Towson, Baltimore Co. Md. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche S. Hamilton

6-DATE OF BIRTH (month, day and year) May 12, 1882

7-AGE. 42 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coal + wood business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER George Hamilton

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Matilda Pitts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Mrs. Blanche S. Hamilton

(Address) Towson, Md.

15- NOV 23 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 ..... 19 24 .. to Nov. 21 ..... 19 24.

that I last saw h.im alive on Nov. 21 ..... 19 24.

and that death occurred, on the date stated above, at 6:48 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Transverse Colon

with extension into Stomach

(Duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Towson, Balto. Md.

Did an operation precede death? Yes Date of Nov. 12, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George B. Brill M. D

19 (Address) Church Homes Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Prospect Cemetery, Towson	Nov. 23, 1924
20-UNDERTAKER. E. LeRoy Stiffler	ADDRESS 1256 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be stated EXACTLY. AGE should be carefully supplied. OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

92246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92246

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hindenach

(a) RESIDENCE No. 2100 Maryland ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va to Nat

PARENTS

10 NAME OF FATHER John Heidenach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mitsom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mrs. Graham Gordon

(Address) 2100 Md Ave

15 NOV 23 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1924, to Nov 22, 1924, that I last saw her alive on Nov 22, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobular pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis & arteriosclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? partial

What test confirmed diagnosis? autopsy

(Signed) Albert L. Anderson, M. D.

, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Nov 25 1924
20 UNDERTAKER	ADDRESS
H. W. Jenkins & Son	Greenmount Ave & Collins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92247

CERTIFICATE OF DEATH.

90 D 92247

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2131 W. Baltimore Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie Amelia Cockrell

(a) Residence No. 2131 W. Baltimore Street St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James J. Cockrell

6-DATE OF BIRTH (month, day and year) Dec. 5, 1847

7-AGE. 76 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Loudon County
(State or Country). Virginia

PARENTS.

10-NAME OF FATHER. John Williams

11-BIRTHPLACE OF FATHER (city or town) Loudon County
(State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Elizabeth Spring

13-BIRTHPLACE OF MOTHER (city or town) Loudon County
(State or Country). Virginia

14- (Informant) Miss Della V. Cockrell

(Address) 2131 W. Baltimore St.

NOV 23 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from September, 19 24, to November 21, 19 24, that I last saw h.. alive on November 20, 19 24, and that death occurred, on the date stated above, at 1.25 A.M. The CAUSE OF DEATH* was as follows:

Mitral Incompetency

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Marr, M. D.

11-21, 1924 (Address) 516 N. Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Nov 25 24
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Balto St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92248

CERTIFICATE OF DEATH.

D 92248

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4013 Wilkens Ave. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Belt

(a) Residence No. 4013 Wilkens Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Francis P. Belt

6-DATE OF BIRTH (month, day and year) Mar. 1, 1863

7-AGE.	If LESS than 1 day,
61 yrs. 8 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Emanuel McKenzie

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jane Kelly

13-BIRTHPLACE OF MOTHER (city or town) Baltimor
(State or Country), Maryland

14- (Informant) George M. Belt
(Address) 116 Oakdale Ave. Catonsville, Md.

15-

Filed....., 192.... .....
Registrar.

NOV 23 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1922 to Nov 21 1924

that I last saw h.. alive on Nov 20 1924

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma 2

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

11-21, 19 24 (Address) 2027 W. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Nov 24 1924
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Eutaw St.

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92249

D 92249

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S Marine Hospital No 1 Baltimore Md

CITY OF BALTIMORE: (NO. ..... ST., 17 WARD)

2-FULL NAME Lerine Kirst

(a) RESIDENCE NO. U.S Marine Hospital # 1 ST., ... WARD 8th Pelham

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S/S Feltore

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Un known

11 BIRTHPLACE OF FATHER (city or town) Un known (State or country)

12 MAIDEN NAME OF MOTHER Un known.

13 BIRTHPLACE OF MOTHER (city or town) Un known (State or country)

14 Informant Self (Address) .....

15 Filed NOV 2 1924 .....19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 .1924. to Nov. 20 .1924.

that I last saw him alive on Nov. 20 .1924.

and that death occurred, on the date stated above, at 3 1/30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? On board

Did an operation precede death? No Date of —

Was there an autopsy? No. What test confirmed diagnosis? Physical findings & Laboratory M. T.

(Signed) ..... M. D.

19 (Address) U.S Marine Hospital # 1 Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Trinity Cemetery — DATE OF BURIAL 11/22 1924

20 UNDERTAKER A. Lissman & Bro. — ADDRESS 1[illegible] E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 92250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 N. Pratt ST. 20th WARD)

2-FULL NAME Mary Virginia Ruehl

(a) RESIDENCE NO. 2500 W Pratt ST., 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Frank Joseph Ruehl

6 DATE OF BIRTH (month, day, and year) May 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	20	yrs 9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

037

9 BIRTHPLACE (city or town) (State or country) Richmond, Va

PARENTS

10 NAME OF FATHER John L. Pockington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Emmer Laura Joy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn Co. Pa.

14 Informant Frank Ruehl

(Address) 2500 W. Pratt St

15 Filed NOV 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 21 Nov 1924

17

I HEREBY CERTIFY, That I attended deceased from 20 Nov, 1924, to 21 Nov, 1924, that I last saw h~~er~~ alive on 21 Nov, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) H. Vance Thompson, M. D.

, 19 (Address) 2505 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF ~~DEATH~~ BURIAL Nov 25, 1924

20 UNDERTAKER F. B. Wippert ADDRESS 1850 W. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92251

CERTIFICATE OF DEATH.

12 D 92251

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 S. Clinton St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Sible

(a) Residence No. 1313 S. Clinton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E.

6-DATE OF BIRTH (month, day and year) July 30-1838

7-AGE. 86 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Watchman Retired

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer. Penna R. R.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not known

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not known

14- (Informant) Christena M. Molz

(Address) 1313 S. Clinton St.

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 20-1924

17- I HEREBY CERTIFY, That I attended deceased from 11/6/24 19.. to 11/20 19.24.

that I last saw h.im alive on 11/14/24 19..

and that death occurred, on the date stated above, at 2.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Hepatitis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) – yrs. – mos. – ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. McGaull M. D

11/20, 1924 (Address) 633-5-St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Carmel Cem	Nov. 24 1924
20-UNDERTAKER.	**ADDRESS**
Zirkler + Zirkler	1739 E. Eager St

N. B.—WRITE PLAINLY, with unfading ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92252

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1225 Ensor St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phoebe C. Hardwick

(a) Residence No. 1223 Ensor St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ WIFE of ~~HUSBAND of~~ Henry H.

6-DATE OF BIRTH (month, day and year) July 19, 1852

7-AGE 72 yrs. 4 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Pa.

PARENTS.

10-NAME OF FATHER, Otley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa.

12-MAIDEN NAME OF MOTHER, Smedley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa

14-

(Informant) Harry B. Hardwick

(Address) 435 N. Linwood

15-

Filed NOV 23 1924, 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 21 1924

I HEREBY CERTIFY, That I attended deceased from Jan. 1 to 20 to Nov. 21 to 24

that I last saw ~~he~~ alive on Nov. 21 to 24

and that death occurred, on the date stated above, at 1201A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. Thurbert M.D.

11-22-24 (Address) 1531 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount

DATE OF BURIAL. Nov 25 1924

20-UNDERTAKER Zerkler & Zirkler

ADDRESS 1734 Eager st

8—WHITE PAPER. WRITE ONLY WITH PEN AND INK. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Edward L Phipps

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92253

100 401 ✓

D 92253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3801 Fernwood Ave ST., N WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ed. L Phipps

(a) RESIDENCE No 3801 Fernwood av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emmaline M. Phipps

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) D 15
(c) Name of employer Balto Copper Works

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Nicholas Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Laura Weston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Emaline M. Phipps
(Address) 3801 Fernwood

15 NOV 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said August (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis,

Aortic Stenosis

(Duration) yrs. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 7 ds

(Signed) H. G. Slade M. D.
(Coroner)

192 (Address) 1243 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Nov 24 192 4
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1734 Eutaw

NAME OF DECEASED MUST be entered on this certificate in the handwriting of the informant. ALL ANSWERS should be plainly written and should be full and complete. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D 42231
D 92254

CERTIFICATE OF DEATH.

✓ 001
91 D 92254
REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Benjamin Steinberg

(a) RESIDENCE No. 1905 W. North Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 12, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abe Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Rassman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 2 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Nov 21, 1924, that I last saw him alive on Nov 21, 1924, and that death occurred, on the date stated above, at 12 Nm.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 3 mos 9 ds.

CONTRIBUTORY (Secondary) Rhinopharyngitis, acute

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Kerper, M. D.

11/24, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rest Normal	11/25 1924
20 UNDERTAKER	ADDRESS
Jack Levin	1409 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital

City of BALTIMORE: (No. 15 St., 96 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Glazer

(a) Residence No... 3315 Carlisle Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 18, 1924

7-AGE, ...yrs.....mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Nuton Glazer

11-BIRTHPLACE OF FATHER (city or town) Russia
(State or Country).

12-MAIDEN NAME OF MOTHER, Celia Frank

13-BIRTHPLACE OF MOTHER (city or town) Maryland.
(State or Country).

14-

(Informant) Hospital

(Address).....

15-

Filed..... 19.. NOV 2 3 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 21 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1924, to Nov. 21, 1924, that I last saw h[er] alive on Nov. 21, 1924, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage of idiopathic origin

.....(Duration).....yrs.....mos. 1/2 ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Transfusion Date of Nov 21.

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) John M. C. Borland, M. D.

, 19 (Address) 58 W. Biddle St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	11/23 19 24
20-UNDERTAKER.	**ADDRESS**
Jack Lewis & Son	739 E Balt

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92256

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 92256

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary O'Sullivan

(a) Residence No. St Agnes Hospital St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F.	W.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885

7-AGE 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Sister Mary Clare

(Address) St Agnes Hospital

15- NOV 23 1924 ROBERT R. PRENTISS, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 9 1924 to Nov. 22 1924

that I last saw h[illegible] alive on Nov. 22 1924

and that death occurred, on the date stated above, at 2 25 P. m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John T. Dwyer M. D

19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral	Nov. 24 1924
20-UNDERTAKER.	ADDRESS
M Healy & Sons	1827 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

176366

D 92257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+49 D 92257

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Frank Burton

(a) RESIDENCE NO. Boyce, Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Va.

PARENTS

10 NAME OF FATHER Harry Burton

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va.

12 MAIDEN NAME OF MOTHER Lilly Sharpe

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924 to Nov 22, 1924, that I last saw him alive on Nov 22, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Brain tumor - Malignant

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? Yes Date of Nov 22-24

Was there an autopsy? Yes Path-Exam

What test confirmed diagnosis?

(Signed) Warfield M Theobald, M. D.

11/22, 19 (Address) Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington DC	Nov 23 1924
20 UNDERTAKER Joseph Ahrens	ADDRESS 224 Bway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 92258

D 92258

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 So. Regester ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LUDWIK KRYSTYNIAK,

(a) RESIDENCE No. 239 So. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22. 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None,

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown,

12 MAIDEN NAME OF MOTHER Bronoslawa Krystyniak,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) MD.

14 Informant Bronoslawa Krystyniak,

(Address) 239 So. Regester St.

NOV 23 1924 Filed ROBERT R. KRAUTH, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22. 1924.

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1924 to Nov 22 1924.

that I last saw her alive on Nov 22 1924,

and that death occurred, on the date stated above, at 10:00 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rysavek, M. D.

1924 (Address) 86, 4 Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	Nov. 24. 1924.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 905 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92259

CERTIFICATE OF DEATH.

124 D 92259

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 N. Howard ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Constance Litynski

(a) RESIDENCE NO. 836 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. -- ds. How long in U. S., if of foreign birth? 4 yrs. 5 mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Smyrna
(State or country) Egypt

PARENTS

10 NAME OF FATHER Joseph Litynski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Cokini

13 BIRTHPLACE OF MOTHER (city or town) Smyrna
(State or country)

14 Informant Anthony Litnyski
(Address) 836 N. Howard Street

15 Filed NOV 24 1924 ROBERT H. KINSEY, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Nov. 23, 1924 (Address) 2 Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/26 1924

20 UNDERTAKER Henry W. Spears & Son

ADDRESS 805 N. Calvert

INFORMATION, WRITTEN BELOW, IS FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Bernard L Palmer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92260

100.001

D 92260

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 Morling Ave (Street) (WARD) 13

2-FULL NAME Burined L Palmer

(a) RESIDENCE NO. 1405 Morling Ave (Street) WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Earl Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Kent P. Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Earl Palmer
(Address) 1405 Morling Ave

15 NOV 24 1924 ROBT. E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1924, to Nov 22, 1924, that I last saw h alive on Nov 21, 1924, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Primary Broncho Pneumonia

(duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M A Fait, M. D.

Nov 22, 1924 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys [redacted]	Nov 24, 24
20 UNDERTAKER	ADDRESS
Chenoweth Son	361 Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92261

CERTIFICATE OF DEATH.

16 001.

D 92261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 827 Union Ave ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Rhyner

(a) RESIDENCE NO. 827 Union Ave ST., ... WARD .....

(Usual place of abode) 2 hrs.

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ½ hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Dan'l Md.
(State or country)

PARENTS

10 NAME OF FATHER Clarence S. Rhyner

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Minnie B. Humphreys

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) N.C.

14 Informant Clarence S. Rhyner
(Address) 827 Union Ave

15 Filed NOV 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1924, to Nov 22, 1924, that I last saw her alive on Nov 22, 1924, and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Premature
Cyanosis
2 Mo. Foetus 2 hrs.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) E. Schmidt, M. D.

(Address) 1600 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden — DATE OF BURIAL Nov 24 24

20 UNDERTAKER Chenowith Son — ADDRESS 3617 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

92262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 v

D 92262

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 Eleanor Ave ST., 17 WARD)

2-FULL NAME Nannie L. Byrd

(a) RESIDENCE No 917 Wilmer Alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther Byrd

6 DATE OF BIRTH (month, day, and year) Apr 15-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Servant 67
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Wm J. Tickner

9 BIRTHPLACE (city or town) (State or country) Essex Co Va

PARENTS

10 NAME OF FATHER Jos. Baines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Luther Byrd
(Address) 917 Wilmer Alley

15 Filed ..... 192 .....
Registrar

AUG 24 1924
ROBERT R. KRAUER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ac. pulmonary oedema (duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Nov 22, 192 4 (Address) 2807 Eden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem.	Nov 25 192 4
20 UNDERTAKER Wm J. Tickner & Sons	ADDRESS N. Y. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1926 92263 — 51 D 92263

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ST., 7 WARD)

2-FULL NAME Joseph Machacek

(a) RESIDENCE NO. 839 N. Washington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Helen Machacek

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Charles Machacek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Hannah Matuska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 24 1926 ROBERT R. KRAETER, Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1926

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1926 to Nov 22 1926.

that I last saw h— alive on Nov 22, 1926.

and that death occurred, on the date stated above, at 12 55 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial Endocarditis with aortic insufficiency, cardiac hypertrophy and dilatation

Failure (duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Acute rheumatic fever

Endocarditis (duration) Several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy Findings

(Signed) Louis E. Martin M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Holy Redeemer — DATE OF BURIAL Nov 25 1926

20 UNDERTAKER P. J. Kuckuck & Sons — ADDRESS North Av

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92264

CERTIFICATE OF DEATH.

38 D 92264

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. Caroline ST., 5 WARD)

2-FULL NAME Samuel Bruce

(a) RESIDENCE No 612 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: XXXX

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Henry Long
(c) Name of employer: Contractor

9 BIRTHPLACE (city or town) (State or country): Norristown N. J.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Edna Saunders
(Address): 612 N. Caroline St

15 NOV 24 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Luetic Aoritis-Aortic Insufficiency

(Autopsy by Dr. Standish Mccleary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S McCallum, M. D. (Coroner.)

11/22/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rachel Kennedy — DATE OF BURIAL: Nov. 24 1924

20 UNDERTAKER: Miss Ida Saunders — ADDRESS: 125 Ashland Ave.

BEFORE signing be CERTAIN SPELLING, AGE Shown be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92265

CERTIFICATE OF DEATH.

13 X 90

D 92265

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2456 Mc Culloh ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Geo W. Joyner

(a) RESIDENCE NO. 2456 Mc Culloh ST., WARD Upper Fairmount Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Joyner

6 DATE OF BIRTH (month, day, and year) Apr. 4 1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ministry

(b) General nature of industry, business, or establishment in which employed (or employer) Preacher

(c) Name of employer and Copper

9 BIRTHPLACE (city or town) (State or country) Somerset County Md

PARENTS

10 NAME OF FATHER John Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Somerset Co~~ Va

12 MAIDEN NAME OF MOTHER Sarah Horsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md

14 Informant (Address) Mrs Louise B. Muir 2456 Mc Culloh

15 Filed NOV 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21st 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1924, to Nov 21st, 1924, that I last saw him alive on Nov 21st, 1924, and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis

(duration) 28 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Somerset County Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas E Bell, M. D.

11 22 1924 (Address) 1224 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Upper Fairmount Md	Nov 24 24
20 UNDERTAKER	ADDRESS
Sam'l W. Crane Son	1400 Mad[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92266

CERTIFICATE OF DEATH.

10 D 92266

1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 Hollins St., 19 Ward)

Registered No.

2-FULL NAME Raphael O'Connell

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1421 Hollins St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 1721

7-AGE, 3 yrs. 2 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. old

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph J O'Connell

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Brennan

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Mrs Nellie O'Connell

(Address) 1324 Eutaw Place

15- Filed NOV 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 21st 1924 to Nov 22nd 1924

that I last saw him alive on Nov 22 1924

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 4 hours ds.

CONTRIBUTORY (Secondary) Diphtheria

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

11/22, 1924 (Signed) M. O'Neill, M. D.

(Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL, Nov 24, 1924

20-UNDERTAKER, W M Rowton

ADDRESS 2235 N

IMPORTANT—PLEASE WRITE UNMISTAKABLY—THIS CERTIFICATE MUST BE PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

D 92267

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sabastiano Fiardiligio

(a) RESIDENCE No. 914 Watson St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Salvatore Fiardiligio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Stella Lubalo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Fiardiligio
(Address) 914 Watson St.

15 Filed 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over body-accidental
(Fell into tub of boiling water
while mother was washing clothes)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Kallen, M. D.
(Coroner.)

11/23/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	Nov 24 1924

20 UNDERTAKER Frank Cook Son ADDRESS 1806 Eutaw

MARGIN

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92268

D 92268

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 N. Milton Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lippa

(a) Residence No. 908 N. Milton Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 41) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. Ignatius Lippa

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Marie Pagunek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant) Marie Lippa

(Address) 908 N. Milton Ave

NOV 24 1924 Filed ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 22/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 19 24 to Nov 22 19 24

that I last saw ... alive on Nov 22 19 24

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

removed by operation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Vertebra

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Sanitarium

Did an operation precede death? Yes Date of Nov 1-24

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) J. Bell Murphy M. D.

19-24 (Address) 6000 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 25 1924
20-UNDERTAKER. Frank Crack Son	ADDRESS 1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—[illegible] PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 92269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 4 D 92269

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 N Rose St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Smith

(a) Residence No. 1409 N. Rose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 20 1924

7-AGE. .....yrs. .....mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto Md.
(State or Country).

PARENTS.

10-NAME OF FATHER. Harry Smith

11-BIRTHPLACE OF FATHER (city or town)..... Balto
(State or Country).

12-MAIDEN NAME OF MOTHER. Dorothy Starr

13-BIRTHPLACE OF MOTHER (city or town)..... Balto
(State or Country).

14-
(Informant) Harry Smith
(Address) 1409 N Rose St

15-
Filed NOV 24 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 23/24

17-I HEREBY CERTIFY, That I attended deceased from Nov 20 1924 to Nov 23 1924 that I last saw h.. alive on Nov 23 1924 and that death occurred, on the date stated above, at 530P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Breech Birth

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm H Register M. D

Nov 24, 1924 (Address) 1301 N Patterson Pk

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Co	Nov 24 1924
20-UNDERTAKER.	**ADDRESS**
Fred C Crosby Son	1106 Gorsuch Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3019 Hudson ST., 1 WARD)

2-FULL NAME Thomas W. Keibler

(a) RESIDENCE NO. 3019 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dena Keibler

6 DATE OF BIRTH (month, day, and year): Nov 15, 1877

7 AGE: Years 47 Months — Days 7 If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Structor 045

(b) General nature of industry, business, or establishment in which employed (or employer): Fruit grower & dr.

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Keibler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Dena Keibler

(Address): 3019 Hudson St

NOV 24 1924

Filed ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22 1924.

17 I HEREBY CERTIFY, That I attended deceased from about June 1, 1924, to Nov. 22, 1924, that I last saw h alive on Nov 21, 1924 and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. Manning, M. D.

11/29 1924 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bauchmans

DATE OF BURIAL: 11/25 1924

20 UNDERTAKER: William Cook

ADDRESS: 502 E

Spec—12-23-21—E.B.R.S.—400 Bks.

Prury.

D 92271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 8 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William A. Prury

(a) Residence No. 1517 N. Bethel St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Johanna Prury

6-DATE OF BIRTH (month, day and year) July 12, 1866

7-AGE, 58 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)..... Saint Clair Scott Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, James Prury

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany ?

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany ?

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed 12 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-22-24

17- I HEREBY CERTIFY, That I attended deceased from 10-15, 1924, to 11-22, 1924, that I last saw h[illegible] alive on 11-22, 1924, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Chronic nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Sx

(Signed) Clark A. Dorsey, M. D.

11-22, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL, Nov 25, 1924

20-UNDERTAKER, Wm. Cook ADDRESS 322 E. Fayette Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3-D 92272

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1925 Mt. Elderry St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....A. Mary Fountain

(a) Residence No. 1925 Mt. Elderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Annie M Siegmann

6-DATE OF BIRTH (month, day and year) Apr 26/1864

7-AGE, 60 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Paper Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Otis

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edw Fountain

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Susan Bauman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-Informant Mrs. Annie M. Siegmann

(Address) 1925 Mt. Elderry

15-

FILED NOV 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 23/1924

17-I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Nov 23, 1924, that I last saw him alive on Nov 22, 1924, and that death occurred, on the date stated above, at 3:25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Peritonitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Hammond Hagner, M. D.

Nov 24, 1924 (Address) 835 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov 24, 1924
20-UNDERTAKER, John Meerdo	ADDRESS 2008 Arsenal

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 92273

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Moreland Ave ST., 15 WARD)

2-FULL NAME "Baby" Holch

(a) RESIDENCE No. 1818 Moreland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hr. 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Alfred E Holch

11 BIRTHPLACE OF FATHER (city or town) Seaford (State or country) Delaware

12 MAIDEN NAME OF MOTHER Blanche Parks

13 BIRTHPLACE OF MOTHER (city or town) Hollands Island (State or country) Maryland

14 Informant Alfred E Holch
(Address) 1818 Moreland ave.

15 Filed NOV 24 1924, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1924, to Nov 23, 1924, that I last saw h— alive on Nov 23, 1924, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Paul Brown, M. D.

(Address) 1837 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Seaford Del	Nov 24 1924
20 UNDERTAKER	ADDRESS
Josiah Joyce	1600 W North Ave

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH D 92274

City Baltimore

County

Village or City Hudson Heights (No.) Fairview Ave 39 (Ward) 27

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George Rubeck

10-001 D 92274

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 44

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6 DATE OF BIRTH March 13, 1853
(Month) (Day) (Year)

7 AGE 71 yrs. 8 mos. 5 da. If LESS than 1 day .... hrs. or .... min.

8 OCCUPATION
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry business, or establishment in which employed or (employer) Retail Bakery

9 BIRTHPLACE (State or country) Germany

PARENTS

10 NAME OF FATHER John Rubeck

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Pokeman

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo Rubeck
(Address) Hudson Heights

15 Filed Nov. 19 1924 H. C. McCormick M.D. Registrar

ROBERT B. KRAUTER
Special Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 18th 1924
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 12th 1924 to Nov 18th 1924
that I last saw h[illegible] alive on Nov 17th 1924
and that death occurred on the date stated above, at 9.65A m.

The CAUSE OF DEATH * was as follows:

Fibrinous Pneumonia

(Duration) 1 yr. 1 mo. 6 da.

Contributory Secondary Cardiac Dilatation

(Duration) yrs. mos. da.

(Signed) H. C. McCormick M. D.

Nov 19 1924 (Address) Aporranbond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Matthews Cemetary	Nov. 21 1924
20 UNDERTAKER	ADDRESS
Geo Leimbach	647 W Pratt St Balto

If more blanks are desired, address Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

Spec.—1-10-24—M&T—1500 Blks.

176260 Pediatrics

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 92275

D 92275

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., 23 Ward)

2-FULL NAME Clinton Richardson

(a) RESIDENCE No. 1228 S. Sharp, St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) May 24, 1924

7 AGE Years	Months	Days	If LESS than 1 day.... hrs. or .... min.
	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None yr. old
(b) General nature of industry, business, or establishment in which employed (or employer) ..... ?
(c) Name of employer ..... ?

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER Clinton Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Nov 17, 1924, that I last saw him alive on Nov. 17, 1924, and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery) & vomiting

(duration) yrs. ..... mos 7 da.

CONTRIBUTORY (Secondary) .....
(duration) yr. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? .....

(Signed) Edmund H. Kerper, M. D.
11/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19 NOV 22 1924

20 UNDERTAKER ..... ADDRESS .....
Per Wm. E. WOODALL

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

35

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

176075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92276

CERTIFICATE OF DEATH.

1 38 D 92276

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 1 WARD)

2-FULL NAME Lawrence Haroun

(a) RESIDENCE NO. 1916 McCulloh St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9 1924

7 AGE — Years: — Months: 2 — Days: 7 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Captain Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Fanny Haroun

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Friend

(Address) JOHNS HOPKINS HOSPITAL

15 NOV 24 1924 1968 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 . 1924 . to Nov 16 . 1924 . that I last saw him alive on Nov 16 . 1924 . and that death occurred, on the date stated above, at 6 00 a. m.

The CAUSE OF DEATH* was as follows:

Congenital syphilis

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary) Diarrhea & vomiting

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann reaction

(Signed) Edgar M. Kaiser, M. D.

11/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner of Health.

NOV 22 1924

92277 — 4-1928—M&T—100 Bks.

Thos. DiViola.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 92277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST., 3 WARD)

2-FULL NAME Thos DiViola

(a) RESIDENCE No. 504 S. Exeter St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	43	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Daniel Di Viola

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary Vulma

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14
Informant Mrs Dr Viola
(Address) 504 S Exeter ST

15
NOV 24 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on body

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Accident falling Gasoline Tank with burning gasoline Explosion

(Signed) H K Gorsuch, M. D.
(Coroner.)

Nov 24, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 25 1924

20 UNDERTAKER Wendell Russell & Son — ADDRESS 3760 Fr

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Keehner)

D 92278

101-801

D 92278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 638 S. Ann ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME John Kaehner

(Residence in Baltimore: No. 3010 Montebello Ave St.; 15 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, May 15, 1855
(Month) (Day) (Year)

7-AGE, 69 yrs. 6 mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Horse Collar Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 088

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Peter Kaehner

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Kaehner

(Address) 638 S. Ann St.

15-

Filed ..... 191.....

ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

NOV 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1924, to Nov 21, 1924, that I saw h... alive on Nov 21, 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(Duration) yrs. mos. ds.

(Signed) Chas. Lamb M. D.

Nov. 22, 1924 (Address) 1112 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Nov 24, 1924

20-UNDERTAKER John F. Fields

ADDRESS 1200 N. Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92279

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N Ellwood ave. WARD) 7

2-FULL NAME Edosia L Chadwick

(a) RESIDENCE NO. 612 N Ellwood ave. WARD North East Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Chadwick

6 DATE OF BIRTH (month, day, and year) Jan 27-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 37

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North East Md

PARENTS

10 NAME OF FATHER Charles G Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Samuel L Chadwick (Address) 612 N Ellwood Ave

15 Filed NOV 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22nd 24

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1924, to 11-22, 1924, that I last saw h[illegible] alive on 11-20, 1924 and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J J Frame M. D.

11/23 1924 (Address) 2939 m[illegible] Elderly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Del.	Nov 25 1924
20 UNDERTAKER	ADDRESS
John C Miller 3019E	Monument St

Stoc—12-23-21—E.B.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92280

CERTIFICATE OF DEATH.

25 90 D 92280

1-PLACE OF DEATH D 92280 Registered No.....

City of BALTIMORE: (No. 100 S. Sixth St. Brooklynn Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda A. Bernschein

(a) Residence No. 100 S. Sixth St. Brooklynn St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Bernschein

6-DATE OF BIRTH (month, day and year) Sept. 27 1868

7-AGE.	If LESS than 1 day,
56 yrs. 1 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Germany
(State or Country).

PARENTS.

10-NAME OF FATHER, Gottlieb Baddatz

11-BIRTHPLACE OF FATHER (city or town). Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Henrietta Gast

13-BIRTHPLACE OF MOTHER (city or town). Germany
(State or Country),

14- (Informant)..... Frank Bernschein

(Address)..... 100 S. Sixth St.

15- NOV 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Sent.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 22 1924

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to Nov 22 1924

that I last saw h.. alive on Nov 22 1924

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Uraemia Contracted Indefinite

(Duration) yrs. 1 mos. 00 ds.

CONTRIBUTORY (Secondary) Vascular Heart Disease

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical

(Signed) T. Hamman M. D.

11/25, 1924 (Address) 1 E Randall St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	11/25 1924
20-UNDERTAKER.	ADDRESS
L. Fenw McCully	130 E Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bosica

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-002

D 92231

CERTIFICATE OF DEATH.

D 92231
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 So Essex St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bosica

(a) RESIDENCE. No. 229 So Essex St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 23 1924

7 AGE — Years — Months — Days 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Grazina Bosica

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Julia Madrachman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Grazina Bosica
(Address): 229 S. Essex St

15 Filed NOV 24 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 19 24, to Nov 23, 19 24, that I last saw h[illegible] alive on Nov 23, 19 24, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Transverse Fracture of Skull — Falling — Blunt Body.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Malformed Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Valentine M. D.

Dec 23 19 24 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 24 19 24
20 UNDERTAKER	ADDRESS
William G. Schaffer	1816 Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92282

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92282

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3026 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominik Lewkiewicz

(a) Residence No. 3026 Elliott St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 25 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 2-1877

7-AGE. 47 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Wathem Lewkowicz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mary Lewkowicz

(Address) 3026 Elliott St

15- Filed NOV 24 1924 Robert R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 22-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17 1924 to Nov. 22 1924

that I last saw him alive on Nov. 22 1924

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(Duration) ... yrs. ... mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical examination

(Signed) Caleb V. Bixler M. D

Nov 23 1924 (Address) 100 S. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem	Nov 25 1924
20-UNDERTAKER.	**ADDRESS**
Stephen Hilchorek	1000 N Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92283

CERTIFICATE OF DEATH.

129

D 92283

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3007 Forsbury ST., 15 WARD)

2-FULL NAME Frank Melvin Frey

(a) RESIDENCE No. 3007 Forsbury ST., 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of: Elizabeth Frey

6 DATE OF BIRTH (month, day, and year): Aug 6 1849

7 AGE: Years 75 | Months 3 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jno B Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Sarah Ann Dubois

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Robt Frey 2 W Lexington St

15 Filed NOV 24 1924 19 ROBERT B. KRUITER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 1924, to Nov 23 1924, that I last saw him alive on Nov 23 1924 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows: Acute Coronary Heart Clot

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Bright's Disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Londsdowne Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine Oedema

(Signed) Chas L Parker M. D.

19 (Address) 3125 W Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Nov 26 19 24

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 804 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92284

CERTIFICATE OF DEATH.

90 D 92284

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 914 Belair Road ST., 27 WARD)

2-FULL NAME John B. Buddy

(a) RESIDENCE NO 914 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) June 26/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner 084

(b) General nature of industry, business, or establishment in which employed (or employer) National Biscuit

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER John Buddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Purnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alice E. Gronewell

(Address) 1002 William St

15 NOV 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gastro- intestinal indigestion (duration) yrs. mos. ds.

(Signed) J. S. Bacon, M. D. (Coroner.)

11/22/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL Nov 24 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92285

CERTIFICATE OF DEATH.

D 92285

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 657 Prince ST. 17 WARD)

2-FULL NAME Sam. Hendrickson

(a) RESIDENCE NO. 657 Prince ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. —

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Hendrickson

6 DATE OF BIRTH (month, day, and year) Dec 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Asbury Park N.J.

PARENTS

10 NAME OF FATHER Sam. Hendrickson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jennie Hendrickson

(Address) 657 Prince St

NOV 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1924, to Nov 21, 1924, that I last saw him alive on Nov 20, 1924, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights

(duration) 0 yrs. 8 mos 3 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) R B Tennyson M. D.

11/21. 1924 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL Nov 24 1924

20 UNDERTAKER Samuel T Handley — ADDRESS 598 Eddie

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92286 — CERTIFICATE OF DEATH. — 100-001 — D 92286

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Blake

(Residence in Baltimore: No. 1622 Druid Hill Ave St.; Yrs.... mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 185[illegible]
(Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. Parker

(Address) Mt. Vernon.

15-

Filed ..... 191.....

NOV 24 1924 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1924, to Nov 22 1924
that I saw h er alive on Nov 21 1924
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Obstruction

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) ..... M.D.
Nov. 22 1924 (Address) 1413 S. Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov 24, 1924

20-UNDERTAKER Samuel Hursley — ADDRESS 528 N Bond St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92287

CERTIFICATE OF DEATH.

31 D 92287

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 East St ST., 5 WARD)

2-FULL NAME Richard Ridout

(a) RESIDENCE NO 142 East St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
80 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Ridout

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lulu Swan
(Address) 304 Forest St

15 Filed NOV 24 1924 ROBERT R. KRA... Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

3 days' (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mag Lue Palmer Interval

(duration) ... yrs. ... mos. ... ds.

(Signed) W W Riley, M. D.

Nov 23 1924 (Address) 116 S 7th St (Coroner.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boney Bros cemetery

DATE OF BURIAL 26 Nov 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92288

CERTIFICATE OF DEATH.

66 D 92288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saulsbury's Ct. St. Edw. Central Ave. 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Lewis.

(a) RESIDENCE No. Saulsbury Ct. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colord	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V. a

PARENTS

10 NAME OF FATHER un known

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Daniel gale

(Address) 283 N. amity St

15 Filed NOV 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 2 ds.

(Signed) G. E. Blades, M. D.

(Coroner)

Nov 21 1924 (Address) 115 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 24 1924
20 UNDERTAKER	ADDRESS
Edward Bryan	Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001
101 D 92289

1-PLACE OF DEATH

City of BALTIMORE: (No. 1218 Belmont ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Kuhlman

(a) Residence No. 1218 Belmont ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael J. Kuhlman

6-DATE OF BIRTH (month, day and year) Nov. 23. 1863

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) (63)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Jacob Resler.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Catherine Braun

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Angelia Kuhlman

(Address) 1218 Belmont ave.

15- Filed NOV 24 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/21/24

17- I HEREBY CERTIFY, That I attended deceased from 11/18, 1924 to 11/21, 1924

that I last saw h. alive on 11/20, 1924

and that death occurred, on the date stated above, at a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wolff, M. D.

11/21, 1924 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	Nov 25 1924
20-UNDERTAKER.	ADDRESS.
George J. Ruth	1305 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Lauers.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92290

CERTIFICATE OF DEATH.

90 D 92290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Pearl st. ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leona Lewis nLauers

(a) RESIDENCE No 231 Pearl st ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Do
(c) Name of employer —

9 BIRTHPLACE (city or town) Dont Know
(State or country) " "

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant None
(Address)

15 Filed NOV 24 1924 ROBERT B. KRAUTER, Registrar
1972 Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, Autopsy or~~ inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis & Heart Disease

(duration) yrs. Don't mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

11-24, 1924 (Address) 1111 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health. NOV 27 1924

Per. Wm E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92291

CERTIFICATE OF DEATH.

101-001

D 92291

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 N. Appleton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Norman Sampson

(a) Residence No. 222 N. Appleton St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 15, 24

7-AGE, ...yrs. ....mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Wilmer Sampson

11-BIRTHPLACE OF FATHER (city or town)..... Alabama
(State or Country),

12-MAIDEN NAME OF MOTHER, Nellie Cross

13-BIRTHPLACE OF MOTHER (city or town).... Md.
(State or Country),

14- (Informant) Wilmer Sampson

(Address) 222 N. Appleton St

15- Filed NOV 24 1924 Howard R. Kemster, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 24/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 23, 19 24, to Nov, 19 24,

that I last saw him alive on Nov 23, 19 24,

and that death occurred, on the date stated above, at 1:10 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. H. Jackson, M. D.

, 19 (Address) 1618 W. Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Cemetery	Nov 24, 1924
20-UNDERTAKER.	ADDRESS
Jno. J. H. Rochester	1403 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec--12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92292

CERTIFICATE OF DEATH.

D 92292

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 Lancaster St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladyslaw Baker

(a) Residence No. 1607 Lancaster St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June. 1914

7-AGE, 10 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eva Kulick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) John Baker

(Address) 1607 Lancaster

15- Filed 192 ROBERT R. KRAUTER Registrar.

NOV 24 1924 Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 22 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 19 24 to Nov 22 19 24

that I last saw him alive on Nov 22 19 24

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rosario, M. D.

Nov 23 24 (Address) 80 Ch Square

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov 25 19 24

20-UNDERTAKER, Wm Fallsfonds — ADDRESS 141 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Church Home & Infirmary

Registered No. 1615

City of BALTIMORE: (No. Broadway, cor Fairmount Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Baby Girl Benson

(a) Residence No. 108 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ———

6-DATE OF BIRTH (month, day and year): Nov 22, 1924

7-AGE: ——— yrs. ——— mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ———

(b) General nature of Industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Oscar Sutton Benson

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Stella Marion Kames

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-(Informant) Stella Kames Benson

(Address) 108 W. Saratoga St.

15-Filed ... 192 ... Robert P. Harrison, Registrar.

Burial Permit Clerk.

1975

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11-24-24

17-I HEREBY CERTIFY, That I attended deceased from Nov 22 19 24, to Nov 24 19 24,

that I last saw h.e.r. alive on Nov 24 19 24

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Injury at birth.

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ... yrs. ... mos. 15 min. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 23, 1924

Was there an autopsy? Fundamental delivery

What test confirmed diagnosis? Spinal Puncture

(Signed) John E. Norment M. D

19 (Address) Church Home & Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL, 19...

20-UNDERTAKER, ... — ADDRESS ... Commissioner Health. NOV 24 1924

CV 24 1924

—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92294

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 3218 Greenmount ave St., W Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Danial H. Weber

(a) Residence No. 3218 Greenmount ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed or Divorced, (Write the word.) Mar.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Weber

6-DATE OF BIRTH (month, day and year) July 4 - 1860

7-AGE. 64 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer 3rd

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Fire Dept.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. John H. Weber

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Sophia Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Annie Weber

(Address) 3218 Greenmount ave

15- DEC 4 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 21, 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1924 to Nov. 21, 1924 that I last saw h. ~~m~~ alive on Nov. 20 1924 and that death occurred, on the date stated above, at 10:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 4

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Howard M. Bubert M. D

, 19 (Address) 2700 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Nov. 25 19 24

20-UNDERTAKER. F. A. Krause & Son — ADDRESS 703 Hanover

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92295

91-003 92295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5605 Pratt Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Anthony Lewenger

(a) RESIDENCE. No. 5605 Pratt Ave ST. 27 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Lewenger

6 DATE OF BIRTH (month, day, and year) Aug 1-1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robert P. Lewenger
(Address) 5605 Pratt Ave

15 Filed NOV 24 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Nov 23, 1924, that I last saw h alive on Nov 22, 1924, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Senility - Cardiac Arrhythmia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Dx

(Signed) C. Engelhardt, M. D.

Nov 25, 1924 (Address) 370 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Nov 26 1924
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

* B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 92296

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 92296

CERTIFICATE OF DEATH.

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1009 W. 40th St. ST. 13 WARD)

2-FULL NAME Elizabeth Mather

(Residence in Baltimore: No. 1009 W. 40th st.

St.; yrs. 71 mos. 0 ds. 0

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~, Married (*Write* the word.)

6-DATE OF BIRTH, May (Month) 5 (Day), 1847 (Year)

7-AGE, 77 yrs. 6 mos. 17 ds.

If LESS than 1 day, ...hrs. or....mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

9-BIRTHPLACE. (State or Country) England.

PARENTS.

10-NAME OF FATHER Joshua Cooper

11-BIRTHPLACE OF FATHER (State or Country) England.

12-MAIDEN NAME OF MOTHER Malley Greenwood.

13-BIRTHPLACE OF MOTHER (State or Country) England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel C. Mather

(Address) 1009 W. 40th St.

15- Filed NOV 24 1924, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 22 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death at 4.30 A.M. on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Disease of Heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Joseph Grissler M. D.
(Coroner.)

Nov 23 1924 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, St Marys Cem Hampden

DATE OF BURIAL, Nov. 25, 1924

20-UNDERTAKER Walter Davis

ADDRESS 3307 Paine St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ... important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 92297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 Hoffman ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Flavell

(a) RESIDENCE NO. Orleans 3301 Wayne ave ST., Germantown WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 42	about	about	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ass't Caretaker
(b) General nature of industry, business, or establishment in which employed (or employer) Cem
(c) Name of employer

9 BIRTHPLACE (city or town) Phila Pa.
(State or country)

PARENTS

10 NAME OF FATHER George Flavell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Thomas M. Pearce
(Address) Phila

15 Filed ....., 192 Robert P. Harrison,
Registrar
NOV 24 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22-24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held on none (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said none (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Cardio-Adrenal

(duration) ....yrs. ....mos. ....ds.

(Signed) [illegible], M. D.
(Coroner.)
Nov. 24, 192 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 2 days

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wayne Junction Phila Pa.	Nov 24 192 4
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son 1938	E. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92298 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92298

91-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor, 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Schmidt

(a) Residence No. Preston & Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~ Married, ~~Widowed, or Divorced~~ (Write the word.) Wife

5a-If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of George Schmidt

6-DATE OF BIRTH (month, day and year) 4 July 1851

7-AGE, 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Henry Swesen

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Anna Myers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-(Informant) Sister Florence

(Address) Preston & Valley

15-FILED NOV 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 24/24

17- I HEREBY CERTIFY, That I attended deceased from to Nov 23 that I last saw h.r alive on Nov 23, 19 24, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Senile dementia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F A Warner, M. D.

Nov 24, 19 24 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Nov. 25, 19 24

20-UNDERTAKER, J. C. Wiedefeld — ADDRESS 914 Gruman Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92299

CERTIFICATE OF DEATH.

D 92299

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 N. Lexington ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Page

(a) RESIDENCE No. 2138 N Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Page

6 DATE OF BIRTH (month, day, and year) Aug 11-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md

PARENTS

10 NAME OF FATHER Jas Sanford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co Md

14 Informant Mrs Wm Manty

(Address) 231 S Calhoun St

15 Robert P. Harrison, Registrar

Burial Permit Clerk

NOV 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23 1924

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1924, to Nov. 23, 1924, that I last saw her alive on Nov 23, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1¼ yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Driscoll, M.D.

, 19 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Savage Cem

DATE OF BURIAL 11-18 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun and Hollins Sts

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92300

CERTIFICATE OF DEATH.

10-001

D 92300

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond A. Fromm

(a) RESIDENCE NO. 723 Mc. Henry St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B. Fromm

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work structural iron worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer Bartlett-Hayward Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. F. Fromm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Baumann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. F. Fromm

(Address) 723 Mc. Henry St.

15 Filed NOV 24 1924, 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Nov. 22, 1924 (Address) 2102 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 25 1924
20 UNDERTAKER Engel & Sons Funeral Parlors	ADDRESS Lafayette

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Harriet M. Garrison)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92301

CERTIFICATE OF DEATH.

D 92301

1-PLACE OF DEATH

REGISTERED NO. 199

CITY OF BALTIMORE: (No. 2300 W Baltimore St. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett M Garrison

(a) RESIDENCE. No 2300 W Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: R.R. Garrison

6 DATE OF BIRTH (month, day, and year): Feb 2nd 1902

7 AGE: Years 22 | Months 9 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Clarence Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eva Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: R. R. Garrison
(Address): 2300 W. Balto St

15 Filed NOV 24 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924, to Nov 23, 1924, that I last saw her alive on Nov 22, 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Miscarriage
complicated by Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Peritonitis General

(duration) yrs. mos. 5 ds.

(a) When was disease contracted if not at place of death? x

Did operation precede death? yes Date of 11-19-24

Was there an autopsy? no

What test confirmed diagnosis? Path of Placenta

(Signed) V. Van Williams, M. D.

, 19 (Address) 601 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Pleasant Md — DATE OF BURIAL: Nov 25th 1924

20 UNDERTAKER: A. Jones — ADDRESS: 1112 S. Gilmor St

Mrs. Harriett B. Garrison Dec'd 11/24/24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92302

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 92302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1202 Edmondson Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles C. C. Charleton

(a) Residence No. 1202 Edmondson Ave Ward.

(Usual place of abode) about 6 (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 5th 1909

7-AGE. 15 yrs. 0 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At School

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Charles W Charleton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Ada Kramer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Charles W. Charleton

(Address) 1202 Edmondson ave

15- Filed Nov 24 1924 19? Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 24/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1924 to Nov 24 1924 that I last saw him alive on Nov 24 1924 and that death occurred, on the date stated above, at 6 a, m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metz M. D.

Nov 24 1924 (Address) 1903 E. Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lexington Va.	11/25/24 19
20-UNDERTAKER. Harry A Wolfe	ADDRESS 1531 N. Longwood

NOV 24 1924

GENERAL INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92303

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 N. Carrollton Ave. 16 WARD)

REGISTERED NO. 78

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celesty Ditch

(a) RESIDENCE NO. 625 N. Carrollton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas. H. Kerchner
(Address) 1522 Wallman

15 Filed NOV 24 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no other history.

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.
(Coroner)

192 (Address) 28 W. Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 25 1924
20 UNDERTAKER	ADDRESS 617
H. C. Branning & Son	N. Schroeder

R.S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

D 92304

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 Evesham Ave. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Gay Benzinger

(a) Residence No. 710 Evesham Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Jan. 21, 1918

7-AGE.	If LESS than 1 day,
6 yrs. 11 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Aloysius T. Benzinger

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Maude Gay

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Mass.

11- (Informant) Mrs. Maude G. Benzinger

(Address) 710 Evesham Ave.

15- NOV 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 23, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924 to Nov 23, 1924

that I last saw him alive on Nov 23 1924

and that death occurred, on the date stated above, at 7.15 P. M.

The CAUSE OF DEATH* was as follows:

Birth Palsy

(Obstetrical Form)

(Duration) 6 yrs. 11 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Entero Colitis

(Duration) ..... yrs. ..... mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? N. Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Fred A. Hoskins M. D.

(Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Bowen Bros Co -	Nov 25, 1924

20-UNDERTAKER.	ADDRESS
H. W. Mears & Son	805 N. Calvert

SHOULD BE WRITTEN IN INK—AS IT IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K·S·A·F
O D A K

Spec—12-23-21—E.S.R.S.—400 Bks.

D 92305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-001

D 92305

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 235 N. Patterson Ave. Ward 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan J. Doyle

(a) Residence No. 235 N. Patterson Ave. St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 5th 1852

7-AGE. 72 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Doyle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Gorman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14-(Informant) John Doyle

(Address) 235 N. Patterson Ave

15-

Filed NOV 25 1924

ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 22-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17th 1924 to Nov. 22nd 1924

that I last saw h in alive on Nov. 22nd 1924

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) A. Palmisano, M. D.

11-24-1924 (Address) 75 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Holy Cross Cem	Nov 25th
20-UNDERTAKER, J. A. Moran	ADDRESS 3000 Ballock,

SHOULD BE PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3509 Forest Park Av St. 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irwin Louis Pritchard

(a) Residence No. 3509 Forest Park Av St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? 52 yrs. 1 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Birkie Evelyn Pritchard

6-DATE OF BIRTH (month, day and year) Sept 26 1872

7-AGE, 52 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Irwin S. Pritchard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Julia Gouley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Mrs B. E. Pritchard (wife)

(Address) 3509 Forest Park Av

15- NOV 25 1924 19.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to November 29, 1924

that I last saw him alive on November 23, 1924

and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) One yrs. Six mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Hedwig F. Kuhlman, M. D.

, 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Nov 26 19 24

20-UNDERTAKER STEWART & MOWEN COMPANY [WILLIAM F. WOODEN, Successor]

ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be stated E... in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec. 6-9-12—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92307

CERTIFICATE OF DEATH.

D 92307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 125 Richmond ST.: | | WARD)

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Healey

(a) RESIDENCE. No. 125 Richmond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerry Healey

6 DATE OF BIRTH (month, day, and year) Unknown 18 74

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Washing & Ironing

(c) Name of employer Coates

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Clark Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Flobafter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant James Coates (Address) 125 Richmond st

15 Filed NOV 25 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1924. to Nov. 23, 1924.

that I last saw h e alive on Nov. 22, 1924.

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Urinary Exam

(Signed) D. Grant Scott M. D.

. 19 (Address) 354 N. Bidde st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbury Ga.	Nov 25 1924

20 UNDERTAKER Samuel F Kemsley ADDRESS N Bidde 78

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92308

CERTIFICATE OF DEATH.

101-001

D 92308

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

2-FULL NAME Fletcher Cole

(a) RESIDENCE No. 944 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed NOV 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-16, 1924, to 11-21, 1924, that I last saw h— alive on 11-21, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Left Hemiplegia (Thrombosis) (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub.

(Signed) Claude A. Dean M. D.

11-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon	Nov 25 1924

20 UNDERTAKER Parsons & Weyforth ADDRESS 364 Park Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92309

CERTIFICATE OF DEATH.

5 31 D 92309

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 221 Colvin St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Green

(a) Residence No. 221 Colvin St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: C

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced ~~Husband of~~ or (or) WIFE of Albert Green

6-DATE OF BIRTH (month, day and year) March 7, 1887

7-AGE. 37 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: General House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto md

PARENTS:

10-NAME OF FATHER: Chas Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto md

12-MAIDEN NAME OF MOTHER: Harriett Boslow

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto md

14- (Informant): Jennie Hall sister

(Address): 217 Colvin St

Filed NOV 25 1924 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1924 to Nov 22 1924

that I last saw h.. alive on Nov 21 1924

and that death occurred, on the date stated above, at 5 46 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D

11/25 1924 (Address) 14 24 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Gen -	11 25 1924
20-UNDERTAKER	**ADDRESS**
Mrs J G Locke	1302 Jefferson

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92310

CERTIFICATE OF DEATH.

47 D 92310

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Glover ST.; 7 WARD)

2-FULL NAME Mary Henkel

(a) RESIDENCE. No. 502 Glover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/20/1878

7 AGE: Years 46 Months 10 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

67

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Henry Henkel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Caroline Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Caroline Henkel 502 N Glover

15 NOV 25 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1922, to Nov 24, 1924, that I last saw h[illegible] alive on Nov 23, 1924, and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

acute Cardiac Dilatation 6 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast (See Below)

(duration) 2½ yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward, M. D.

19 (Address) 225 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel

DATE OF BURIAL: Nov 27 1924

20 UNDERTAKER: John Ulrich

ADDRESS: 208 Aisquith

Spec—12-23-21—E.B.R.S.—400 Eks.

D 92311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No. D 92311

City of BALTIMORE: (No. 2621 Guilford Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Oberdalhoff.

(a) Residence No. 2621 Guilford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Oberdalhoff

6-DATE OF BIRTH (month, day and year) Jan 19-1881

7-AGE. 43 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Henry Oberdalhoff.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Quack

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Annie Oberdalhoff Wife

(Address) 2621 Guilford Ave

15- NOV 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 23 1924

17- I HEREBY CERTIFY, That I attended deceased from July 10 1924 to Nov 23 1924

that I last saw him alive on Nov 23 1924

and that death occurred, on the date stated above, at 5 58 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Clive Murray M. D.

Nov 25 1924 (Address) 1221 W Lafayette Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park	11-26 1924
20-UNDERTAKER, Wm Chas A S Rohde	ADDRESS 600 N Arlington Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92312

CERTIFICATE OF DEATH.

89 D 92312

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Folsom ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora agnes Tudor

(a) RESIDENCE NO. 414 Folsom ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. D. Tudor

6 DATE OF BIRTH (month, day, and year) March 6. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10 NAME OF FATHER John Twigg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada.

12 MAIDEN NAME OF MOTHER Bertha DeHenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Chas D Tudor

(Address) 414 Folsom St

15 Filed ..... 19.. ROBERT R. KRAUTER, Registrar

NOV 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from 11. 3. 24, 19.., to 11. 24. 24, 19..,

that I last saw h.. alive on 11. 21. 24, 19..,

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

angina Pectoris

Sudden

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) arterio Sclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) P Lilig B. Tawby M. D.

11. 24, 20 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 11- 26 1924

20 UNDERTAKER E B Hale

ADDRESS 115 E Mt St

Cor.—1-12-23—M&T—100 Bks.

D 92313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18-001

D 92313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 McElderry ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Pruitt

(a) RESIDENCE No. 1611 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Pruitt

6 DATE OF BIRTH (month, day, and year): Nov. 17 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	—	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Eugene R. Pruitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma A. Cointwright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Eugene R. Pruitt (Address): 2536 W. Baltimore St

15 Filed ... 192 ... Registrar

NOV 25 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained ... find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxiation from Gas Stove (duration) Dead when found

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Chas. B. Horton M. D.
(Coroner.)

Nov. 24 1924 (Address) Curtis Bay Balto, Md

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side ...

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 26 1924

20 UNDERTAKER: Harry T. Witzke — ADDRESS: 1534 Monterey Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92314

CERTIFICATE OF DEATH.

179 D 92314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj Franklin Swann

(a) RESIDENCE NO 611 Archer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Estelle Swann

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. Paint & Color works

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Swann

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Estelle Swann
(Address) 611 Archer St.

15 NOV 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entire Upper part body burned

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Explosion Benzine Mixt

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

, 192 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn

DATE OF BURIAL 11/24 1924

20 UNDERTAKER Jos Johnson & Bro

ADDRESS 1127 E Balto st

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Cor.—1-12-23—M&T—100 Bks.

D 92315

HEALTH DEPARTMENT—CITY OF BALTIMORE 001 92315

CERTIFICATE OF DEATH.

181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1319 E Lombard ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Bendell.

(a) RESIDENCE NO. 1319 E Lombard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? 4 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Peddler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs J. Bresch

(Address) 3022 Pressman st

15 Filed ... 192 ROBERT R. KRAUTER, Registrar

NOV 25 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 192 4

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc.

Gas Poisoning 3 hr.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia (duration) yrs. mos. ds.

(Signed) J. Gaston Clinton Bixby M. D.

(Coroner)

192 (Address) 142 W Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cemetery DATE OF BURIAL 11/25 192 4

20 UNDERTAKER Sol Levinson & Bro ADDRESS 127 E Balto st

INSTRUCTIONS: AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 92316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92316

1-PLACE OF DEATH U. S Marine Hospital No1.

CITY OF BALTIMORE: (No. Fathman nd ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Conway
U S Marine Hospital No1

(a) RESIDENCE NO. 79 Weir st ST., WARD Phila Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 mo. mos. de. How long in U. S., if of foreign birth? yrs. mos. de.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self
(Address)

15 Filed NOV 25 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1924, to Nov. 24, 1924, that I last saw him alive on Nov 24, 1924, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary, Chronic, active

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical & Laboratory & X Ray.

(Signed) M. H. Foster, M. D.

Nov 25, 19 (Address) U S Marine Hospital No 1 Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery — DATE OF BURIAL 11/25 19 24

20 UNDERTAKER Sol. Levinson Bro ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 57

D 92317

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST., 11 WARD)

2-FULL NAME Mrs Jane Edna Fuss

(a) RESIDENCE NO. Uniontown Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female.	white.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	60	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Pennsylvania ?

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania ?

12 MAIDEN NAME OF MOTHER Martha Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant (Address) F Shriner Uniontown Md.

15 Filed NOV 25 1924 ROBERT B. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov-24- , 1924 , to Nov-25 , 1924 , that I last saw her alive on Nov. 25 , 1924 , and that death occurred, on the date stated above, at 3:15A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) ? yrs. 24 hrs. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Bridge Md — DATE OF BURIAL: Nov 27 1924

20 UNDERTAKER: W M Routson — ADDRESS: 228 N [illegible] St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

oc—12-23-21—E.B.R.S.—400 Bks.

92318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

74 D 92318

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1909 N. Eutaw St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Becker

(a) Residence No. 1909 N. Eutaw St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Becker

6-DATE OF BIRTH (month, day and year) Nov. 3. 1858

7-AGE, 66 yrs. mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Salem Keeper

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Becker.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-(Informant) Margaret F. Becker

(Address) 1909 N. Eutaw St.

15-Filed NOV 25 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 24 24

17- I HEREBY CERTIFY, That I attended deceased from July 30 1920 to Decemb 24 1924

that I last saw him alive on November 24 1924

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ... yrs. — mos. 7/12 ds.

CONTRIBUTORY (Secondary) —

..... (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) C. W. Hoffman, M. D.

11/24 1924 (Address) 1102 Bro. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine Cem. DATE OF BURIAL, Nov. 26..., 1924

20-UNDERTAKER, Mrs. Wm. F. Teufel & Son ADDRESS 30 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.F.S.—400 Bks.

D 92319

HEALTH DEPARTMENT—CITY OF BALTIMORE

44

D 92319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1144 Hanticoke St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Smokvena.

(a) Residence No. 1144 Hanticoke St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Smokvena

6-DATE OF BIRTH (month, day and year) Jan. 7. 1868

7-AGE. 56 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Concreter
(b) General nature of industry, business, or establishment in which employed (or employer). B & O.
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Andrew Smokvena

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Austria

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Austria

14-Informant. Elizabeth Smokvena

Address. 1144 Hanticoke St.

15-Filed NOV 25 1924 ALBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 24 24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923 to Nov. 24, 1924 that I last saw h alive on Nov 24 1924 and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia of Stomach.

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) M. L. Hullinger, M. D.

11/25 1924 (Address) 682 Woodington Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL. Nov. 27, 1924

20-UNDERTAKER. Mrs. Jno. H. Teufel ADDRESS. 801 N. Fayette St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT--CITY OF BALTIMORE

92320

CERTIFICATE OF DEATH

3 D 92320

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 828 N Parrish St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Leander Ivy

(Residence in Baltimore: No. 828 N Parrish St.: 19 yrs. 0 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov. 2, 1897 (Month) (Day) (Year)

7 AGE: 27 yrs. 22 mos. 23 ds. If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9 BIRTHPLACE (State or country): S. Carolina

PARENTS

10 NAME OF FATHER: Wm M. Ivy

11 BIRTHPLACE OF FATHER (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Nancy Mathis

13 BIRTHPLACE OF MOTHER (State or country): Georgia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm M. Ivy

(Address) 828 N. Parrish

15

Filed ..... 191.... ROBERT P. KRAUTER, REGISTRAR

NOV 25 1924 Board of Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 25, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Nov 24 1924 that I saw him alive on Nov 24, 1924 and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:

Acute Ulcerative Endocarditis

(Duration) .... yrs. .... mos. 4 .... ds

Contributory (SECONDARY) Anaemia and Asthma (Duration) 5 yrs. 3 mos. ds.

(Signed) J. H. Hutchins M. D.

11-25, 1924 (Address) 1202 S. Holland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 27 192[illegible]

20 UNDERTAKER: Sam'l. Feast & Son — ADDRESS: 1100 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 92321

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 W. Lafayette Av ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Smith

(a) RESIDENCE. No. 1330 W. Lafayette Av. ST.,..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or WIFE of) Rebecca Smith

6 DATE OF BIRTH (month, day, and year) Sept 6 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Trucker 13

(b) General nature of industry, business, or establishment in which employed (or employer) Transportation

(c) Name of employer Wash Baltimore & Ann R.R.

9 BIRTHPLACE (city or town) (State or country) Pennsylvania Accomac Co. Va

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Hack

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country) Va

14 INFORMANT Mrs Ellen Smith (wife)

(Address) 703 W. Lexington St

15 NOV 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23 1924

17

I HEREBY CERTIFY, That I attended deceased from November 21, 1924, to November 23, 1924, that I last saw him alive on November 22, 1924, and that death occurred, on the date stated above, at 1105 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Alfred A. Bendix, M. D.

(Address) 84 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Herzel	Nov 26 1924
20 UNDERTAKER	ADDRESS
Sam'l R. Cake Sons	1400 Myrtle Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 303 S. Collington Ave. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Edward Sewell.

(a) Residence No. 303 S. Collington ave. 1 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 8th 1924

7-AGE.	If LESS than 1 day,
....yrs. 5 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Balto.. Md.....
(State or Country).

PARENTS.

10-NAME OF FATHER. Elifton R. Sewell

11-BIRTHPLACE OF FATHER (city or town). Balto. Md
(State or Country).

12-MAIDEN NAME OF MOTHER. Lillian M. Ford

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or Country).

14-

(Informant). Lillian M. Sewell (Mother)

(Address). 303 S. Collington Ave.

NOV 25 1924

ROBERT R. KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 23rd 1924

17- I HEREBY CERTIFY, That I attended deceased from

Nov 15 1924 to Nov 23 1924

that I last saw him alive on Nov 23 1924

and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(Duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Hamut S. Fisher M. D

, 1924 (Address) 8326 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cemetery	Nov. 25 1924
20-UNDERTAKER. Lilly-Zeien	ADDRESS 4038 Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92323

16-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Wilhelm ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Riley Winton Mabe

(a) RESIDENCE No. 1826 Wilhelm ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 27-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Winton R. Mabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Theresa Steinle

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant (Address) Winton R. Mabe 1826 Wilhelm St.

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

NOV 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924, to Nov 24, 1924.

that I last saw h[illegible] alive on Nov 24, 1924,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis.

(Dysentery?)

Duration unknown.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Nuttels, M. D.

19 24 (Address) 2151 Sheldon Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov. 26 1924

20 UNDERTAKER: George L. Schwab — ADDRESS: 2101 Pulaski Ave.

S. S. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92324 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 92324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Church Home & Infirmary) 8 145 Registered No.....

City of BALTIMORE: (No.....St., ...Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian M. Thorne.

(a) Residence No. 2612 Keyser St St., ...Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Thorne

6-DATE OF BIRTH (month, day and year) Aug 15 1899

7-AGE. 25 yrs. 2 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) Her home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Newfoundland

PARENTS.

10-NAME OF FATHER. Mathew Greenslade

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Newfoundland

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Mrs Allen Thorne

(Address) 2612 Keyser St

15- Filed NOV 25 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk. Hazel

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1924 to Nov 24 1924

that I last saw her alive on Nov 24 1924

and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 3. 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. W. Bauerdeen M. D

19 (Address) Church Home Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill | DATE OF BURIAL. Nov 27. 1924

20-UNDERTAKER. John F Denny | ADDRESS 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92325

CERTIFICATE OF DEATH.

100 D 92325

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 723 Harlem Avenue St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Margaret Friend

(a) Residence No. 723 Harlem Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 9, 1869

7-AGE, 55 yrs. 4 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) William Wood

(Address) 712 N. Monroe Street

15- Filed NOV 25 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1924, to Nov 25, 1924, that I last saw her alive on Nov 24, 1924, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ✓ yrs. ✓ mos. 9 ds.

CONTRIBUTORY (Secondary) None

(Duration) ✓ yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No By ✓

What test confirmed diagnosis? Physical Examination

(Signed) Nunc Otis M. D.

11-25 1924 (Address) 1203 W. Fayette Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Lot Redeemer	Nov 26, 1924
20-UNDERTAKER	ADDRESS
Lee B Cook	1003 W Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92326

CERTIFICATE OF DEATH.

D 92326

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Ward Sp St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registered No.....

2-FULL NAME. William L. Willingham

(a) Residence No. Forty Third St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah C. Willingham

6-DATE OF BIRTH (month, day and year) Dec 4th 1844

7-AGE. 79 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer). Truck Farm

(c) Name of employer.

9-BIRTHPLACE (city or town). Balto. Co.

(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. William Willingham

11-BIRTHPLACE OF FATHER (city or town). Balto. Co.

(State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Anna Wolfe

13-BIRTHPLACE OF MOTHER (city or town). Balto. Co.

(State or Country). Maryland

14- (Informant). Sarah C. A. Willingham

(Address). Fullerton Md.

15- Filed NOV 25 1924 Robert F. Harris Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 23-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 19 24 to Nov. 23 19 24

that I last saw h. alive on Nov. 23 19 24

and that death occurred, on the date stated above, at 10 35 A.M.

The CAUSE OF DEATH* was as follows:

Left sided lobar pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 17/24

Was there an autopsy? no

What test confirmed diagnosis? Clin & Phys. tests

(Signed) Geo. B. Lydiard M. D.

19 (Address) St. Josephs Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery

DATE OF BURIAL. Nov. 26th

20-UNDERTAKER. Frederick Lassahn Sons

ADDRESS Fullerton

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92327

D 92327

CERTIFICATE OF DEATH.

X 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sydenham Hospital ST., 61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Laurence Pabst

(a) RESIDENCE NO. Joppa Road & Burton Ave. - Fullerton, Balto Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fullerton (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER H. L. Pabst

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Viola Burton

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country)

14 Informant Father (Address)

15 Filed NOV 25 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1924, to Nov 24, 1924, that I last saw him alive on Nov. 24, 1924, and that death occurred, on the date stated above, at 7 45 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Positive Diph. Culture

(Signed) Myron G Tull, M. D.

11/25 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov. 25, 1924
20 UNDERTAKER	ADDRESS
Fred K. Lassahn & Sons	Fullerton

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92328

CERTIFICATE OF DEATH.

D 92328

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen Parker

(a) Residence No. Good Shepherd Convent, St. Wards

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of do not know

6-DATE OF BIRTH (month, day and year) — — 1843

7-AGE, 81 yrs. mos. ds.

If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) do not know

12-MAIDEN NAME OF MOTHER, do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), do not know

14- (Informant) Sister Mary St. Helena

(Address) Good Shepherd Convent

15- (Filed) NOV 25 1924 Robert P. [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 22-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1924 to Nov 23rd 1924

that I last saw her alive on Nov. 22nd 1924

and that death occurred, on the date stated above, at 9.20 a. m.

18-CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colles fracture left leg

(Duration) yrs. mos. 23 ds.

19-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What was confirmed diagnosis? Examination of gens.

(Signed) Roades Fayerweather M. D.

, 19 (Address) 529 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

20-PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem

DATE OF BURIAL 11-26 1924

20-UNDERTAKER J. Slingluff

ADDRESS 1318 Eutaw St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92329

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 E. Lombard ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Winkler

(a) RESIDENCE No. 1711 E. Lombard St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 81 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Winkler

6 DATE OF BIRTH (month, day, and year) Feb. 28th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	86	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Truck Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Margaret Hopkins (Address) 1711 E. Lombard St.

15 Filed NOV 25 1924 .19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1924, to Nov 23, 1924, that I last saw h in alive on Nov 23, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. X mos. X ds.

CONTRIBUTORY (Secondary)

(duration) X yrs. X mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Urine Ex

(Signed) J. Edw. Sullivan, M. D.

. 19 (Address) 130 S. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Nov. 26, 1924
20 UNDERTAKER	ADDRESS
Fredk. Leas & Sons	Fullerton

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 92330 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-801 D 92330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1608 Ashburton ST. 15 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George James Adams

(a) RESIDENCE. NO. 1608 Ashburton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. -2- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23rd 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	-2-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Willie Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape Fear North Carolina

12 MAIDEN NAME OF MOTHER Mamie Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lafayette Dadeston Co. Va.

14 Informant (Address) Willie Adams 1608 Ashburton St

15 Filed NOV 25 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 23rd 1924, to Nov 24th 1924, (that I last saw him alive on Nov 24th 1924, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature rupture of membranes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eight months pregnancy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan, M. D.

Nov. 19 24 Address 1701 W Saratoga Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery Dorchester Co. Md.	Nov. 25 1924
20 UNDERTAKER	ADDRESS
M Hurley & Sons	1820 North Ave

Burial Permit Clerk.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D Elways

(a) RESIDENCE No. Leeds, Cecil Co Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 5, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Darby Pa

PARENTS

10 NAME OF FATHER H. P. Elways

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn N.Y.

12 MAIDEN NAME OF MOTHER Lottie Moffat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hyattsville Md

14 Informant Mother

(Address)

15 Filed NOV 25 1924, 19 Robert F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924, to Nov. 25, 1924,

that I last saw him alive on Nov. 25, 1924,

and that death occurred, on the date stated above, at 11:00 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Mastoiditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11/23/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Tull M. D.

11/25/24 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md.

DATE OF BURIAL Nov 26 1924

20 UNDERTAKER Wm J Tolson & Sons

ADDRESS North & Payne ave

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D 92332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92332

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH Homewood Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME Edwards Jerode Stermann Sr.

(a) RESIDENCE NO. 2337 N. Calvert ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Homewood Hospital Baltimore, Md

PARENTS

10 NAME OF FATHER Edw. Jerode Stermann

11 BIRTHPLACE OF FATHER (city or town) Towson (State or country) Maryland Md

12 MAIDEN NAME OF MOTHER Shea.

13 BIRTHPLACE OF MOTHER (city or town) Towson (State or country) Maryland Md

14 Informant Edw. Stermann
(Address) 2337 West St.

15 Filed NOV 25 1924 Robert P. Harrison, Registrar
Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24 1924 to Nov 25 1924
that I last saw him alive on Nov. 24. 1924
and that death occurred, on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Maurice E. Shamer M. D.

11/25 1924 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's - Govans Md	Nov 26 1924
20 UNDERTAKER	ADDRESS
J. C. Wiedefeld	914 Gruenth Ave

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 641 S. Belnord ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina G Manzo

(a) Residence No. 641 S Belnord Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 2 1924

7-AGE. ..yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, August Manzo

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Rosalie Langer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) August Manzo

(Address) 641 S Belnord Ave

15-

NOV 25 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 19 24 to Nov 24 19 24

that I last saw h[illegible] alive on Nov 24 19 24

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D F Herzog M. D.

Nov 24 1924 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL, Nov. 25. 1924

20-UNDERTAKER. Mendell & Appelton — ADDRESS 37 E Lanvale

Instructions must be carefully followed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92334

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-903 ✓ D 92334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. JosephHospital ST., | WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Lipkowski

(a) RESIDENCE No 928 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) Jan 18,1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Lipkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Teofila Licke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Lipkowski
(Address) 928 S. East Ave

15 Filed 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

OV25 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Frac. Skull-occipital Region
accidental-overturned automobile
in which she was a passenger
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Powers, M. D. (Coroner.)

11/24/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Nov 26 1924
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1000 N. Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter Attached) Full Story 12 E Eager

D 92335

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 92335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Spalding Ave ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Rose

(a) RESIDENCE No. 309 Spalding Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daisy Surm Rose

6 DATE OF BIRTH (month, day, and year): 6-24-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Geo Harris Co 1008

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William H Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louisa Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Daisy S. Rose
(Address) 309 Spalding Ave

15 Filed: Robert P. Harrison, Registrar

NOV 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-25- 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Nov. 25, 1924.

That I last saw him alive on Nov 24, 1924.

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,

Myocarditis

(duration) Years yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Chronic

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Renal func. Blood nitrogen

Nov 25, 1924 (Address) 12 E. Eager St. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 26 1924
20 UNDERTAKER: William Cook	ADDRESS: 501 E North Ave

I.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CONSULTATIONS
AFTERNOONS BY APPOINTMENT

JOHN A. LUETSCHER, M. D.
12 EAST EAGER STREET
BALTIMORE

DEC 1 1924

Dec 6/24

Dear Dr Jones,

Kindly correct age in death
certificate of William Henry Rose who died
on Nov. 25, 1924 of Chr. nephritis (uraemia)
& myocarditis.

He was born June 24, 1852; making
his age. 72 yrs 5 mos & 1 day.

Very sincerely D92335

Jno A Luetscher

Attach to original certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92336

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 E. Fayette ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Ellis

(a) Residence No. 1410 E. Fayette ave St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the Word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. F. Ellis

6-DATE OF BIRTH (month, day and year) Nov. 14, 1894

7-AGE. 30 yrs. ..... mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Charles A. Wellhide

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie R. McKechan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto City

14- (Informant) Annie R. Wellhide

(Address) 1410 E. Fayette Ave

15- Filed NOV 25 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1924 to Nov. 24, 1924 that I last saw h.. alive on Nov. 24, 1924 and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Chorea

(Duration) ..... yrs. 4 mos. ..... ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Hall M. D.

11/24 1924 (Address) 1901 Harrison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Nov. 24, 1924
20-UNDERTAKER, Wm. Cook	ADDRESS 502 E. Madison

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1757 D 92337

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92337

CERTIFICATE OF DEATH.

7 x 90

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Samuel Denby

(a) RESIDENCE NO. Lake Shore, ST., Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fenie Denby ?

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
27	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 21

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Denby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Victoria Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1924 to Nov 24, 1924, that I last saw him alive on Nov 24, 1924, and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis
Aortic and mitral insufficiency
Cmyocardial failure.

(duration) yrs. 2½ mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary congestion

(duration) yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes Positive blood culture

What test confirmed diagnosis? Autopsy

(Signed) Louis C. Wilson M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge. Md

DATE OF BURIAL Nov 26, 24

20 UNDERTAKER John H Longfellow

ADDRESS 1077 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

92338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145-D 92338

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Kohler

(a) RESIDENCE NO. 1514 N. Chapel ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Kohler

6 DATE OF BIRTH (month, day, and year) Oct 29/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Goldie Beatty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant William Kohler

(Address) 1514 N Chapel St

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1924, to Nov 24, 1924, that I last saw him alive on Nov 24, 1924, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Caesarian Section for ruptured uterus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 22/24

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. L. Stone, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 28 1924

20 UNDERTAKER Frank Enoch Son — ADDRESS 1716 Eutaw Place

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92339

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balt. Gen. Hosp. ST., 8 WARD)

2-FULL NAME William H. Reinhard.

(a) RESIDENCE NO. 1503 N. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Reinhard.

6 DATE OF BIRTH (month, day, and year) May 13 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	44	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Work.

(b) General nature of industry, business, or establishment in which employed (or employer) Chemists

(c) Name of employer McCormick Co.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Leonard Reinhard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Helwig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine Reinhard.

(Address) 1503 N. Collington Ave.

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 1924, to Nov. 25, 1924.

that I last saw him alive on Nov. 25, 1924

and that death occurred, on the date stated above, at 6:05 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,

Myocarditis & Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symptoms

(Signed) J. E. Petegnief M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 28 1924

20 UNDERTAKER Jos. Sarnah Sapoles — ADDRESS 1004 Aisquith St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-2.—E.B.R.S.—400 Bks.

Wholesale. 4239 York Road.

92340

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

D 92340

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. So Balt. Gen. Hospl St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Gardner

(a) Residence No. 4724 Little York Rd St. Govans Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6-DATE OF BIRTH (month, day and year) May 15-61

7-AGE. 63 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer). do

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. James Gardner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ewick — Crow

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) James L. Gardner

(Address) 4727 Little York Rd

15- Filed NOV 26 1924 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 25/1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 19 24 to Nov 25 19 24

that I last saw h[illegible] alive on Nov 23 19 24

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. W. Wheaton M. D

19 (Address) 4239 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Dulaney Valley Gdns	Nov 29 1924
20-UNDERTAKER.	ADDRESS
Wm Cook Son & Co	[illegible]

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 92341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92341

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Harford ave (ST.) 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel B. Jones

(Residence in Baltimore: No. 1722 Harford ave St.; 28 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 23, 1840 (Month) (Day) (Year)

7-AGE, 84 yrs. 7 mos. 1 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. County

PARENTS.

10-NAME OF FATHER, Aquilla Jones

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co

12-MAIDEN NAME OF MOTHER Sarah Tracy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Wansant

(Address) 1722 Harford ave

15-

Filed..... 1924 ..... 191.....

..... Assist. Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23rd 1924, to Nov 24th 1924, that I saw h[illegible] alive on Nov 24th 1924, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Valvula disease of the Heart

(Duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Focal Emphaciem

Age 84yrs (Duration) yrs. mos. 14 da.

(Signed) D. A. Waldron M. D.

11-25, 1924 (Address) 210 East Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....da. In the State .....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Grace M. E. Burying Ground Christmas Eve | DATE OF BURIAL, Nov. 27, 1924

20-UNDERTAKER Balto Co, Md, ADDRESS 1203

Henry Lutz N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92342

CERTIFICATE OF DEATH.

37 D 92342

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jake Hubbelman

(a) RESIDENCE No 8 N. Pine St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie Hubbelman

6 DATE OF BIRTH (month, day, and year) Feb 18/1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing 045
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Laib Hubbelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Menacha -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto. St

15 Filed NOV 26 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov25/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis & emphygema (duration) 10 yrs. mos. ds.

(Signed) J. Sol Coen, M. D.
(Coroner)

11/26/24, 192 (Address) 508 E. orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 11 26 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

TION is very important See instructions on b

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92343

D 92343

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 33 E. 21st St. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E. Buck

(a) Residence No. 33 E. 21st St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 2, 1837

7-AGE 87 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS

10-NAME OF FATHER, John Buck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Adeline A Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Mr Howard Buck

(Address) 33 E 21st St

15-

Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 24, 24

17- I HEREBY CERTIFY, That I attended deceased from Several yrs. to Nov 24, 19 24

that I last saw h[illegible] alive on 11/24 19 24

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Alice Hall, M. D.

11/24, 1924 (Address) 2020 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cem. DATE OF BURIAL. Nov 26, 1924

20-UNDERTAKER. John A Mitchell ADDRESS 1204 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92344

CERTIFICATE OF DEATH.

129

REGISTERED NO. D 92344

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 826 Edmondson Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Golden

(a) RESIDENCE NO. 826 Edmondson Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 8 70

7 AGE Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 70

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER John L. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Virginia Golden

(Address) 826 Edmondson Ave

15 Date NOV 26 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1924, to Nov. 23, 1924, that I last saw h alive on Nov. 23, 1924, and that death occurred, on the date stated above, at 11-20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urine analysis etc.

(Signed) Thos. Norton, M. D.

11/26/24 (Address) 888 N. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL 11/26/1924

20 UNDERTAKER Emanuel V. Hensley ADDRESS 578 Wdale St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓

REGISTERED NO. D 92345

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD) 17

2-FULL NAME William Johnson

(a) RESIDENCE No. 1223 Shields Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Wrigh

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D. C.

14 Informant Hospital Records
(Address) M.T.H.

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1924, to Nov. 23, 1924, that I last saw him alive on Nov. 23, 1924, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) James F. Wheeler, M. D.

11-23-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	11/26 1924
20 UNDERTAKER	ADDRESS 578
Samuel D. Hensley	W. Biddle

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 2182 M&T—1500 Bks.

92345
17469

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 112 D 92346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

CITY OF BALTIMORE (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter C Hershberger

(a) RESIDENCE No. Frederick Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Hershberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hazel Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends
(Address) JOHNS HOPKINS HOSP.

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1924, to Nov 25, 1924, that I last saw him alive on Nov 25, 1924, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Diarrhea (not dysentery) [illegible]

(duration) yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H. Kerper M. D.

11/26 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery Frederick Md	11/27 1924
20 UNDERTAKER C C Carty	ADDRESS Frederick Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92347

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

CERTIFICATE OF DEATH.

Registered No. D 92347

1-PLACE OF DEATH

City of BALTIMORE: (No.) 745 N. Chester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Nau

(a) Residence No. 745 N. Chester St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Barbara Nau

6-DATE OF BIRTH (month, day and year) Oct 1/63

7-AGE. 61 yrs. 1 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Himself

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Chas. Nau

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Barbara Nau

(Address) 745 N. Chester St

15- Filed NOV 26 1924 ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 24/24

I HEREBY CERTIFY, That I attended deceased (from) 11-6-24 to Nov 24 19 24

that I last saw him alive on Nov 23 19 24

and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

1a Grippe

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 18 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Ruppelt M. D.

11-27-1924 (Address) 606 N. Patterson Pk.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. 11/27 1924

20-UNDERTAKER. Philip Hennig — ADDRESS 2016 Orleans St.

Under the Law, BURIAL PERMIT cannot be issued UNLESS CAUSE OF DEATH is correctly, supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 92348

CERTIFICATE OF DEATH.

90 D 92348

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2835 Raynor ave ST.) (WARD 46)

2-FULL NAME Christian Otto

(a) RESIDENCE No. 2835 Raynor ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Matilda Otto

6 DATE OF BIRTH (month, day, and year) Nov 3 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
84	84	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Germany —

PARENTS

10 NAME OF FATHER Henry Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Wm Seibert

(Address) 2836 Raynor ave

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17 I HEREBY CERTIFY, That I attended deceased from June, 1924, to Nov. 24, 1924, that I last saw h alive on Nov. 24, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) myocardial degeneration

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

Nov 25 1924 (Address) 2802 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	11-27 1924
20 UNDERTAKER Wm M. Gaulbert	ADDRESS 2835 Raynor ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 159-002 D 92349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Belt Ave. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. Kelly.

(a) RESIDENCE NO. 1817 Belt Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. -- mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	--	--	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leo Kelly.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Hendricks

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore Md

14 Informant Margaret Kelly. (mother).
(Address) 1817 Belt Ave.

15 Filed NOV 26 1924 ROBT. B. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Steinhardt, M. D. (Coroner.)

Nov. 25, 1924 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	11-26 1924
20 UNDERTAKER E. O. B. Hanke	ADDRESS 115 E. West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92350

CERTIFICATE OF DEATH.

101 D 92350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 E 37th St. St.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Flaherty

(a) RESIDENCE. No. 631 E. 37th St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 24-1872

7 AGE: Years 52 Months Two Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Andrew Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Virginia Muir

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Alice Frank

(Address): 631 E 37th St

Filed NOV 26 1924 19.... WALTER R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 24

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Nov. 24, 1924, that I last saw h.. alive on Nov. 23, 1924, and that death occurred, on the date stated above, at 9 12 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia—Lobar Both lungs

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Lu. L. Watkins, M. D.

Nov. 24 1924 (Address) 2 24 E. 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Penn at Baltimore

DATE OF BURIAL: Nov 27 1924

20 UNDERTAKER: J. A. Moran

ADDRESS 3000 E Baltimore

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92351

CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO. D 92351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M. Stonk

(a) RESIDENCE NO. 615 Falls Road Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER James Gibson

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Municipal Hospital Record
(Address)

15 Filed NOV 26 1924, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-25, 1924, to 11-22, 1924

that I last saw h— alive on 11-22, 1924

and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension;
Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Ist autopsy

(Signed) Claude G. Bruen, M. D.

11-23 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Nov 29 1924

20 UNDERTAKER J. G. Moran

ADDRESS 500 E. Baltimore

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92352

CERTIFICATE OF DEATH

179 D 92352

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3507 Clairmont St No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruby Girard

(a) RESIDENCE No 3507 Clairmont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) — —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Wm A. Girard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Bullock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Mother Mrs A Girard
(Address) 3507 Clairmont St

15 Filed NOV 26 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry, find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Scald from coffee
(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blades M. D.
(Coroner)
Nov 25 1924 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery | DATE OF BURIAL Nov 28 192

20 UNDERTAKER John A. Moran | ADDRESS 3306 E Balto St

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 92353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Graves 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Markland Ave St.; 37 WARD)

REGISTERED NO. C 92353

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry L. Spear

(Residence in Baltimore: No. 405 Markland ave St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September (Month) 23 (Day), 1861 (Year)

7-AGE, 63 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance
(b) General nature of industry, business, or establishment in which employed (or employer): Broker

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Spear

11-BIRTHPLACE OF FATHER (State or Country), Baltimore md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virgina Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. L. Rhude

(Address) 405 Markland Ave.

15-

Filed ..... 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

NOV 26 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 23 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1923, to Nov 23 1924, that I saw h— alive on Nov 23 1924, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Right Shoulder

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Fracture of R. Humerus

(Duration) yrs. mos. ds.

(Signed) Thos. H. Rhodes M. D.

Nov 24, 1924 (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 26 191.

20-UNDERTAKER John M Weber — ADDRESS 1803 Bank

17

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Jaruoiski

HEALTH DEPARTMENT—CITY OF BALTIMORE

167-001

D 92354

CERTIFICATE OF DEATH.

D 92354

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2314 Boston ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Jaruoiske

(a) RESIDENCE NO. 2314 Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer) Pants maker
(c) Name of employer self Saloon Keeper

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Pienczyski sister In
(Address) 223 Eastern ave

15 Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar

NOV 26 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to Death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide Gas Poisoning 3hr

(duration) hrs. mins. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner), M. D.

192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 28 1924
20 UNDERTAKER	ADDRESS
John McNeber	1803 Bank st

NOTE—WHERE PRACTICABLE, WITH CONSENT OF RELATIVES, PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9[illegible]55

HEALTH DEPARTMENT—CITY OF BALTIMORE

1857 92355

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Hosp St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Irene Fagan

(Residence in Baltimore: No. St Elizs. Home St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Col.	Single

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
2 yrs. 9 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... —
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hsd

9-BIRTHPLACE, (State or Country). ? Md

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. McC Trapnell

(Address).....

15- NOV 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Probable cause Accidental
Fall (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner)
Nov 24 1924 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER,	ADDRESS
	NOV 26 1924

MORGUE

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92356 CERTIFICATE OF DEATH. 68 D 92356

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Cosgrove

(a) RESIDENCE NO. 640 W. Franklin ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenville, Pa.

PARENTS

10 NAME OF FATHER Calvin Pettit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Adeline Garber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Municipal Hospital Records
(Address)

15 Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar
1977 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-18, 1924, to 11-23, 1924, that I last saw living alive on 11-22, 1924, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Narcotism (Morphine)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Bruce, M. D.

11-23 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS NOV 26 192

Commissioner of Health.

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92357

CERTIFICATE OF DEATH.

129 D 92357

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632 E 25th (St.:) 9 (Ward)

2-FULL NAME Mr. Alfred Choffel Woolley

(a) RESIDENCE. No. 1632 E 25th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? 71 yrs. 7 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Mary A. Woolley

6 DATE OF BIRTH (month, day, and year): Apr. 9 1853

7 AGE — Years: 71 — Months: 7 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Transfer Clerk for

(b) General nature of industry, business, or establishment in which employed (or employer): Hochschild-Kohn & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mass.

PARENTS

10 NAME OF FATHER: Chappel Woolley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs. Mary A. Woolley 1632 E. 25th St.

15 Filed ..... 192... Registrar

NOV 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25 1924

17 I HEREBY CERTIFY, That I attended deceased (from) Oct. 25. 1924. (to) Nov 25. 1924.

that I last saw him alive on Nov 25. 1924.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis & Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Leo. L. Zimmerman M. D.

11/26 1924 (Address) 2858 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Nov. 29 1924

20 UNDERTAKER: Henry Hosch & Son — ADDRESS: 1301 E Eager St

Duration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92358

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 92358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N Mourse ST., 70 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie C. Ghent

(a) RESIDENCE No. 401 N. Mourse ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert D. Ghent

6 DATE OF BIRTH (month, day, and year) July 23 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Madison Maryland

PARENTS

10 NAME OF FATHER John E Bromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Madison Md

12 MAIDEN NAME OF MOTHER Hester H Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Madison Md

14 Informant Olivia M Thompson

(Address) 2804 Mosher St

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17 I HEREBY CERTIFY, That I attended deceased from November 19 24, to November 25, 1924, that I last saw her alive on November 24, 1924, and that death occurred, on the date stated above, at 6 - a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C E Buxton, M. D.

11/25, 1924 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Nov 28 1924
20 UNDERTAKER	ADDRESS
E. J Fanning	1200 Baltimore

MAY 2 1924 TO 1925

GE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17688

92359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92359

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME Anthony Galdikas

(a) RESIDENCE No. 401 N Pratt St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. — mos. — ds. How long in U. S., if of foreign birth? 19 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen

6 DATE OF BIRTH (month, day, and year) September 21, 1879

7 AGE: 45 Years 2 Months 4 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tayler

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia Lithuania ?

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rosada
(Address)

15 Filed NOV 26 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1924 to Nov 25, 1924, that I last saw h— alive on Nov 25, 1924, and that death occurred, on the date stated above, at 4.52 a. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency + stenosis, aortic insufficiency auricular fibrillation, cardiac hypertrophy and dilatation, myocardial failure

(duration) 23 yrs. — mos — da.

CONTRIBUTORY (Secondary) Probably acute rheumatic fever (duration) 23 yrs. — mos. — da.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Louis E Martin M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 29 1924
20 UNDERTAKER	ADDRESS
John Greblinskas	425 S Paca St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

92360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D 92360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Blum

(a) RESIDENCE NO 900 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 3, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: school boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Clarence Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary Spindler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mary Spindler Blum
(Address): 900 E. Wager St

15 Filed NOV 26 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24/24 [92]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis-ruptured intedtine-automobile accident

Nov 17/24

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Case, M. D. (Coroner)

Nov 25/24, 192 (Address) 508 E. North A

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemy — DATE OF BURIAL: Nov 28 1924

20 UNDERTAKER: Elmer W Conklin — ADDRESS: 914 E Eager

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

92361 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92361

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 402 S. Parrish St. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah A. Spurry

(a) Residence No. 402 S. Parrish St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced [redacted] (or) WIFE of Joshua Spurry

6-DATE OF BIRTH (month, day and year) Feb. 5, 1842

7-AGE. 82 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Caroline Co. Md.

PARENTS

10-NAME OF FATHER, John T. Price

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Caroline Co. Md.

12-MAIDEN NAME OF MOTHER, Mary Countis

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Caroline Co. Md.

14- (Informant) Carroll Spurry
(Address) 1971 Patterson Park Ave.

15- Filed NOV 26 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from June, 19 19 to Nov 26 19 24
that I last saw h alive on Nov 25 19 24
and that death occurred, on the date stated above, at 7.20P m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

10 (Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 12 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) H. L. Kozak M. D.

, 19 (Address) 28 W Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn — DATE OF BURIAL. Nov 28, 1924

20-UNDERTAKER. John F Denny — ADDRESS 915 E 15th St

IMPORTANT. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 92362

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 314 S. Bouldin ST., (Ward) No

2-FULL NAME Barbara Klein

(a) RESIDENCE NO 314 S. Bouldin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Klein

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria Hungary

PARENTS

10 NAME OF FATHER John Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Katherine Ottmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Hungary

14 Informant John Lang
(Address) 412 E. Pittsburg St.

15 NOV 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide

Knife Wounds

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Staden, M. D.

(Current) Nov 26 192 (Address) 1417 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Nov. 27 1924
20 UNDERTAKER	ADDRESS
A. Howard Evans	322 E. Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92363

CERTIFICATE OF DEATH.

D 92363

57

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 6 Lombard Green ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Weinberg

(a) RESIDENCE NO. 214 N. Collington Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon Weinberg

6 DATE OF BIRTH (month, day, and year): Apr. 8, 1866

7 AGE: Years 58 Months 7 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St Louis Mo.

PARENTS

10 NAME OF FATHER: Abraham Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rebecca Speyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Solomon Weinberg

(Address) 214 N. Collington Ave

NOV 26 1924

Robert F. Duffy, Registrar

. 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1924, to Nov 26, 1924,

that I last saw h... alive on Nov 26, 1924,

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Oct 20 (duration) Nov 26 mos. 1924

CONTRIBUTORY (Secondary) Diabetes

(duration) Nov 26 mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? Yes Date of Oct 20-1924

Was there an autopsy? No

What test confirmed diagnosis? Laboratory, Findings Operation

(Signed) Lewis Walker, M. D.

. 19 (Address) University Hospital Lombard & Greene Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 11/28/1924

20 UNDERTAKER: David Sondheim

ADDRESS 118-20 W. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92364

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw. T. Savage

(a) RESIDENCE NO 919 Wilmer alley ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward S. Savage

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Lentzmann

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Germany

14 Informant Mrs. R. E. Elliott
(Address) 1725 Ashland Ave.

15 Filed ... 192 ...
Robert P. Harrison, Registrar

V 26 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry.~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry.~~) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot wound in Chest

(duration) ... yrs. 2 hours ... mos. ... ds.

CONTRIBUTORY (Secondary) Shot by M Ryan

(duration) ... yrs. ... mos. ... ds.

(Signed) W. K. Jowell (Coroner.), M. D.

11-26, 1924 (Address) 919 Wilmer Savage St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Nov. 28 1924
20 UNDERTAKER Mrs. R. E. Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D. 92362 D. 92365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Charlotte Palmer

(a) RESIDENCE NO. 204 Pearl St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frank

6 DATE OF BIRTH (month, day, and year) ? 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	-	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Eagby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

NOV 26 1924 Robert P. Harrison Registrar

Burial Permit o...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1924, to Nov 25, 1924, that I last saw her alive on Nov 25, 1924, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix

(duration) 1 yr. mos. ... ds.

18 Where was disease contracted if not at place of death? 204 Pearl St.

Did an operation precede death? Yes. Date of Nov. 20, 24.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Ill McKinlay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 28 1924

20 UNDERTAKER Wm R. G. Elliott — ADDRESS 1725 Ashland

If LESS than 1 day, ... hrs. or ... min.

Should be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92366

CERTIFICATE OF DEATH.

117

D 92366

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 12th WARD)

2-FULL NAME Baby Annetta Klostzli

(a) RESIDENCE NO. 444 East 20th Street ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female.	white	Baby.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Baby.

6 DATE OF BIRTH (month, day, and year) April 27-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter J Klostzli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Marguerite Jaffner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Mother (Address) 444 E 30th St.

15 Robert P. Harrison, Registrar

2 6 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1924, to Nov 26, 1924, that I last saw her alive on Nov 26, 1924 and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis. (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home + 444 E. 30th St.

Did an operation precede death? Yes Date of Nov 22-1924

Was there an autopsy? No. Clinical and

What test confirmed diagnosis? ~~Surgical~~

(Signed) E. W. Coons, M. D.

, 19 (Address) Maryland Gen. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 28 1924
20 UNDERTAKER William Cook	ADDRESS 501 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92367

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 S. Carlton ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose M. Campbell.

(a) RESIDENCE NO. 16 S. Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel P Campbell

6 DATE OF BIRTH (month, day, and year) Oct 14/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Edwin Shaffer.

11 BIRTHPLACE OF FATHER (city or town) Shenandoah (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Stowers

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Daniel P. Campbell

(Address) 16 S. Carlton

15 Filed 11 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/24, 1924, to 11/24, 1924,

that I last saw her alive on 11/24, 1924,

and that death occurred, on the date stated above, at 5 45 P.m.

The CAUSE OF DEATH* was as follows:

Immediate cause: None made at Univ Hosp Diag.

Probably Gastric ulcer or carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Temporary Cem. Jumpers	11/28 1924

20 UNDERTAKER H. Walter Davis

ADDRESS 330 Penna Ave

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Signed by permission of Coroner Dr. Potter

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92368

CERTIFICATE OF DEATH.

REGISTERED NO. 92368

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 East 30th ST., (WARD) 90 1st N.E. Dist.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Martha Smith

(a) RESIDENCE NO. 706, E 30th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Warner H. Smith

6 DATE OF BIRTH (month, day, and year) 6-10-1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER John Boughman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Anna A. Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Mrs Carrie Mangl

(Address) 706 E 30th

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

V26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 25 1923, to Nov 24, 1924,

that I last saw h alive on March 24, 1924,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? N Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL Nov 27 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mont

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Cor.—1-12-28—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92369

CERTIFICATE OF DEATH.

D 92369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. In front of 727 Harvey St. ST. 24 WARD) 170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas P. Clark.

(a) RESIDENCE No. 1228 Hull St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grain trimmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Clark.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Cadden.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant James Clark. (father)
(Address) 1228 Hull St.

15 Filed NOV 26 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage,
Pistol shot wound in the heart.
Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Leonhardt, M. D. (Coroner)

Nov. 26, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 11/27 1924

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1422 Light st.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 92370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92370

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Loudon Ave. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne M. Schatz

(a) RESIDENCE No. 219 Loudon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): Oct. 16, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	23	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Michael Schatz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Giese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Louis Rieker

(Address): 219 Loudon Ave

15 Filed V 26 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov. 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922. to Nov. 25, 1924.

that I last saw he alive on Nov. 20, 1924.

and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis 45

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray - Sputum - Serk. Sanabarm

(Signed) Howard M. Rubert, M. D.

11/25 1924 (Address) 2700 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Nov 28 1924

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92371

100-001

D 92371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2657 Edmondson Ave ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Calvin Nitchman,

(a) RESIDENCE NO. 2657 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie Wilson Nitchman

6 DATE OF BIRTH (month, day, and year) Sept 15 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer —

990

9 BIRTHPLACE (city or town) East Berlin (State or country) Pa.

PARENTS

10 NAME OF FATHER Cornelius Nitchman

11 BIRTHPLACE OF FATHER (city or town) Adams Co. (State or country) Pa.

12 MAIDEN NAME OF MOTHER Susan Helsel

13 BIRTHPLACE OF MOTHER (city or town) East Berlin (State or country) Pa.

14 Informant John Nitchman (Address) 2657 Edmondson Ave.

15 Filed NOV 26 1924, 19 Robert P. Harrison, Burial Permit Clerk Registrar

V 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 25 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-19, 1924, to 11-25, 1924, that I last saw h[illegible] alive on 11-25, 1924, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Pickard, M. D.

11-25, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL NOV 28 1924, 19

20 UNDERTAKER Geo W Little

ADDRESS EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92372

CERTIFICATE OF DEATH.

(Dundalk)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Colgate ave. ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Graham Rogers. Sr.

(a) RESIDENCE. No. 301 Colgate ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Rogers

6 DATE OF BIRTH (month, day, and year): July 13-1853

7 AGE: Years 71 Months 4 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Towson Md

PARENTS

10 NAME OF FATHER: George H Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Isabell Batchelor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mr. Frank Rogers 301 Colgate Ave

15 Filed NOV 27 1924 19 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1924.

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1924, to Nov 26, 1924.

that I last saw him alive on Nov 25, 1924,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Rice, M. D.

11/26. 1924 (Address) Trinity Rd Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Jas. R. Church Bal. Co. | DATE OF BURIAL: Nov 28 24

20 UNDERTAKER: W. C. Brooks | ADDRESS: Sparks Md

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EET

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92373 — CERTIFICATE OF DEATH. — 74001 — D 92373

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2264 Schroeder St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Williams

(a) Residence No. 2264 Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Williams

6-DATE OF BIRTH (month, day and year) June 1860.

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Edward Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va.

12-MAIDEN NAME OF MOTHER, Rosie Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14-

(Informant) Cornelia Anderson.

(Address) 226 N. Schroeder St.

15-

Filed NOV 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 16, 1924 to Nov 23, 1924

that I last saw her alive on Nov 23, 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (2nd attack)

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. R. Calvary M. D.

, 19 (Address) 1537 Druid Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Auburn Cemetery	Nov. 25, 1924
20-UNDERTAKER	ADDRESS
Maude P. Snowden	1525 Ashland Ave

Should be CAREFULLY and COMPLETELY answered. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

175 9 3 92374

CERTIFICATE OF DEATH.

11-6 D 92374

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Samuels

(a) RESIDENCE NO. 2136 Mc Culloughst Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of #

6 DATE OF BIRTH (month, day, and year) Sept 16, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....#.....

(c) Name of employer .....#.....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Silas Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Blanch Gates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 27 1924 16 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1924, to Nov 26, 1924, that I last saw h[illegible] alive on Nov 26, 1924, and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Meningitis (Pfeiffer bacillus)

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of 11/5/24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A W Jacobson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	11/27/24
20 UNDERTAKER	**ADDRESS**
Daniel Eastan 916	Penna Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-24—M&L—100 Blks.

D 92375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-002 D 92375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Claude Dobbs

(a) RESIDENCE NO 1621 Ensor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma G. Dobbs

6 DATE OF BIRTH (month, day, and year) Oct 15/1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) City Water Dept.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Claude Dobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward Dobbs
(Address) 1621 Ensor St

15 Filed NOV 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage- Autotruck & St. car collision
(Fractured skull both parietal Reg.)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Coles, M. D. (Coroner.)

11/26/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 11/28 192 4

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave

DEATH is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 74-001 D 92376

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1601 Hicksley Place St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Zipple

(a) Residence No. 1601 Hicksley Place St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
~~FE~~MALE	WHITE	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 1, 1850

7-AGE.	If LESS than 1 day,
74 yrs. 5 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Jos. A. Zipple

(Address) 1601 Hicksley Place.

15-

Filed ..... 19..

NOV 27 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) November 26th 1924

17- I HEREBY CERTIFY, That I attended deceased from November 24th 1924 to November 26th 1924

that I last saw h.. alive on November 25th 1924

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

1 Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? By Physical examination

(Signed) P. E. Selby M. D.

Nov 26th 1924 (Address) 800 E. Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	11/28, 19 24

20-UNDERTAKER,	ADDRESS
George J Ruth	1735 Harford Av

In filling out the answers to these questions, PHYSICIANS should state CAUSE OF DEATH clearly, plainly and concisely. Supplies. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 Carrol st St., 21 Ward)

Registered No. D 92377

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of wm and Mary Anna Riecke

(a) Residence No. 1113 Carrol st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 25 1924

7-AGE. 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 16 hrs. or. 5 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Riecke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Anna Spencer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11- (Informant) William Riecke

(Address) 1113 Carroll st

15- Filed 192 ROBT. R. KRAUSE Registrar.

NOV 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 24 to Nov 26 24

that I last saw h alive on Nov 25 24

and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 11 Newton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Dausity Cemetery	Nov 27 1924
20-UNDERTAKER,	ADDRESS
Jos Joerdens Son	207 S Paca

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 38 D 92378

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3006 Windsor Ave. ST., 15 WARD)

2-FULL NAME Louis Smith

(a) RESIDENCE NO. 3006 Windsor Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Smith.

6 DATE OF BIRTH (month, day, and year) May. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71.	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 015

(b) General nature of industry, business, or establishment in which employed (or employer) Contracting

(c) Name of employer Bennett. Bro.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Wife (Lizzie Smith)

(Address) 3006 Windsor Ave

15 Filed NOV 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to Nov. 26, 1924, that I last saw h-im alive on Nov 26, 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Rupture of Aneurism of Aorta.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) Edgar L Graners, M. D.

, 19 (Address) 1500 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.

DATE OF BURIAL 11/28 1924

20 UNDERTAKER Clarence G. Trimper

ADDRESS 776 Hanover

mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92379

CERTIFICATE OF DEATH.

90 D 92379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 149 W. Belvidere Ave St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelia Louise Price

(a) RESIDENCE No. 149 W. Belvidere ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. W. Price

6 DATE OF BIRTH (month, day, and year) May 23 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Savannah Ga
(State or country)

PARENTS

10 NAME OF FATHER Hetbrick

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Celia L Bruce
(Address) 1490 W. Belvidere

15 Filed ....192.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (or autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Pulmonal Disease
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

Nov 26, 1924 (Address) 3632 Roland Ave

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Nov. 28 1924

20 UNDERTAKER Wm Pickues Sons ADDRESS North St Pa

IMPORTANT—Physicians are requested to make this certificate of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS should be given. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92380

CERTIFICATE OF DEATH.

129 D 92380

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17 WARD)

2-FULL NAME Stephen Holland

(a) RESIDENCE NO. 721 N. Rosemont ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffer

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Timothy Holland

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Feaney

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Hospital Record
(Address)

15 Filed ....., 19.... MICHAEL R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20/1924

17

I HEREBY CERTIFY, That I attended deceased from 11/23/24 19..... to 11/20/1924, that I last saw him alive on 11/20/1924 7:00 P. m. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia - Hypertension

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Holley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	11/28/1924

20 UNDERTAKER John J. Cowan Son 2101 [illegible] ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92381

CERTIFICATE OF DEATH.

129 D 92381

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 340 W Hilton ST., (or) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella A. Saville

(a) RESIDENCE NO. 340 W Hilton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ the late Geo Saville

6 DATE OF BIRTH (month, day, and year) Aug. 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath
(State or country) England

PARENTS

10 NAME OF FATHER Chas H Abum

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Essex

13 BIRTHPLACE OF MOTHER (city or town) Holland
(State or country)

14 Informant Geo P Russell
(Address) 340 W Hilton St

15 Filed NOV 27 1924 19 JOSEPH R. KNIGHTLY, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17

I HEREBY CERTIFY, That I attended deceased from November 20 1924 to November 25 1924.

that I last saw her alive on Nov 25 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:—

Chronic Myocarditis
Mitral & Aortic Insufficiency
Chronic Parenchymatous Nephritis
(duration) 5 yrs mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings - Urine Test

(Signed) J. H. Bosley, M. D.

Nov 26 1924 (Address) 501 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Nov 27, 24

20 UNDERTAKER Robt Johnson Inc

ADDRESS W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92382

CERTIFICATE OF DEATH.

101-001

D 92382

Registered No.

1-PLACE OF DEATH

City of BALTIMORE; (No. 231-N Fremont St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Bell Scott

(a) Residence No. 231-N Fremont St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Lena Scott

6-DATE OF BIRTH (month, day and year) 3-15-94

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Coal Trimmer

(b) General nature of Industry, business, or establishment in which employed (or employer). Day Laborer

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Blackstone Va.

PARENTS.

10-NAME OF FATHER. Walter Scott

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Blackstone Va

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Blackstone Va

14- (Informant) Lena Scott

(Address) 231-N-Fremont St.

15- Filed NOV 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-24-24

17- I HEREBY CERTIFY, That I attended deceased from 11/16/, 19 24 to 11/24/ 19 24.

That I last saw h alive on on 11/24 19 24

and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. E. Carlson, M. D.

11/25, 1924 (Address) 808 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem Nov 27 1924

20-UNDERTAKER. ADDRESS

Samuel T Hawley 1012 Eddison St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ~~CAUSE OF DEATH~~

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92383 — X 25-003 — D 92383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Florannna Douglas

(a) RESIDENCE NO. Phillippi, W. Va ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —"—

6 DATE OF BIRTH (month, day, and year) May 30 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) ..... —"—
(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Robert Lee Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Alta Pack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant ..... Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1924, to Nov 26, 1924,
that I last saw h—alive on Nov 26, 1924,
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:
Toxic polyneuritis (Secondary to Acrodynia)

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kemper, M. D.
11/27, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phillippi W. Va — DATE OF BURIAL Nov 27 1924

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Emory

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92384

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1523 Beason St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Walton.

(a) RESIDENCE NO. 904 E St. Sparrows Point. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If ~~single, widowed, or divorced~~ HUSBAND of (or WIFE of) Catherine Walton.

6 DATE OF BIRTH (month, day, and year) November 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	0	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer): Steam shovel.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va.

PARENTS

10 NAME OF FATHER Elijah Walton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Sarah J. Russell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Ida Nagle. (sister)
(Address) 904 E St. Sparrows Point.

15 NOV 27 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Albert L. Reinhardt, M. D.
(Coroner)

Nov, 26, 1924 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., da. In the State yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery Nov 28 1924 DATE OF BURIAL

20 UNDERTAKER John A. Moran ADDRESS 320 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92385

HEALTH DEPARTMENT—CITY OF BALTIMORE

1883 09 92385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 3 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph(Suess) Salanja

(a) RESIDENCE No 220 S. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of nnnn

6 DATE OF BIRTH (month, day, and year) Feb 9/1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Nicolas Salanja

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Kirsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Amelia Salanja
(Address) 220 S. Bond St

15 Filed NOV 28 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov25-24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemothorax-punctured by rib- struck by automobile- accidental-boy in street

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Waters, M. D. (Coroner.)

Nov 27 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Nov. 28 1924

20 UNDERTAKER Lilly and Zile

ADDRESS 403 S. Wolfe St.

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92386

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001
74 D 92386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 637 N. Kenwood Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Mason

(a) Residence No. 637 N. Kenwood Ave St., 7 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Mason.

6-DATE OF BIRTH (month, day and year) Oct. 28-1868

7-AGE. 56 yrs. 0 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Julius W. Heuschaefer

11-BIRTHPLACE OF FATHER (city or town) Balto.
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Catherine Schumann

13-BIRTHPLACE OF MOTHER (city or town) Balto.
(State or Country), Md.

14- (Informant) John F. Heuschaefer
(Address) 818 N. Luzerne Ave.

15- Filed NOV 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 25-1924

17- I HEREBY CERTIFY, That I attended deceased from January 5 1923, to Nov 25 1923, that I last saw her alive on Nov 19 1924 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (Duration), yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Caleb V Bosley, M. D.

Nov 27 1924 (Address) 1003 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. — DATE OF BURIAL, Nov. 29th 1924

20-UNDERTAKER. Lilly & Ed Zeiler — ADDRESS 403 S. Wolfe St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

174871
D 92387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 17 D 92387

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L Allender

(a) RESIDENCE No Parkersburg W. Va ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. 9 How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month and year) May 16 1868

7 AGE — Years: 56 — Months: 6 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oil Well Driller

(b) General nature of industry, business, or establishment in which employed (or employer): 886

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Parkersburg W. Va

PARENTS

10 NAME OF FATHER: Berry Allender

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant: Hospital Records
(Address) .....

15 NOV 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month and year) Nov 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1924, to Nov. 27, 1924, that I last saw him alive on Nov. 27, 1924, and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

1 hr. Hemiplegia Embolism of Brain
2 hrs. Myocarditis Hypertrophy & Dilatation
Cardiac Failure

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Blood Examination.

(Signed) R. Hooper Smith, M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkersburg W. Va — DATE OF BURIAL: 11/28 1924

20 UNDERTAKER: Henry W Meade & Son — ADDRESS: Balto

mation should be carefully supplied. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. See instructions may be properly classified. Exact statement of OCCUPATION on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92388

CERTIFICATE OF DEATH.

90 D 92388 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 112 S. Highland Ave. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Heien

(a) Residence No. 112 S. Highland Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Heien

6-DATE OF BIRTH (month, day and year) Feb. 27, 1844

7-AGE. 80 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Albert Heien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mary A. Heien

(Address) 112 S. Highland Ave.

15- NOV 28 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from November 19, 1924 to Nov. 25, 1924

that I last saw her alive on Nov 24, 1924

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Examination

(Signed) Caleb N. Bixler, M. D.

Nov 29 1924 (Address) 100 S Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov. 28, 1924
20-UNDERTAKER,	ADDRESS
H. Vander & Sons	1710 Fleet St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92389

CERTIFICATE OF DEATH.

31 ✓ D 92389

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2715 Eastern Ave. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisabeth Bauer

(a) Residence No. 2715 Eastern Ave., St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav C. Bauer

6-DATE OF BIRTH (month, day and year) Jan 26, 1884.

7-AGE.	If LESS than 1 day,
40 yrs. 10 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Dondorf

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Catherine Keller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mr. Gustav Bauer

(Address) 2715 Eastern Ave.,

15-

NOV 28 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 26, 1924

I HEREBY CERTIFY, That I attended deceased from Feb. 15 1922 to Nov. 26 1924

that I last saw her alive on Nov 26 1924

and that death occurred, on the date stated above, at 11.56P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. A. Neer M. D.

11-27-24 (Address) 402 E. East Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Nov. 30, 1924
20-UNDERTAKER.	**ADDRESS**
H. Vandeveer & Sons	1710 Fleet St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 92390

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 579 Hoffoman ST. 17 WARD)

2-FULL NAME Mazie Hehderson

(a) RESIDENCE. No. 579 Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Henderson

6 DATE OF BIRTH (month, day, and year) Oct 20, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER John Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellicott city md

12 MAIDEN NAME OF MOTHER Annie Plater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick md

14 Informant Annie Plater Barnes
(Address) 579 Hoffman st

15 Filed ..., 19... ROBERT R. KRAUTER Registrar

NOV 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1924, to Nov 25, 1924, that I last saw h[illegible] alive on 11/24, 1924, and that death occurred, on the date stated above, at 1245 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cold

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W H Hopkins, M. D.

, 19 (Address) 616 Edelman

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel centery	Nov 28 1924
20 UNDERTAKER Mrs Jas H. Dennis	ADDRESS 1303 Pressman.

Rev T. E. Kelson

IMPORTANT.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 N. Mount Street St., 19 Ward) Registered No. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Brogden Jr.

(a) Residence No. 404 N. Mount Street. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Negro	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 21st. 1920

7-AGE,	If LESS than 1 day,
4 yrs. 10 mos. 5 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Edward Brogden Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Florene Edwards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) John E. Brogden Sr.
(Address) 404 N. Mount St

15- Filed NOV 26 1924 19... ROBERT B. KRAUTER, Registrar.
~~Assistant Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-26-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24th. 1924 to Nov. 26th. 1924

that I last saw him alive on Nov. 26th. 1924

and that death occurred, on the date stated above, at 9:45 a. m

The CAUSE OF DEATH* was as follows:

Acct. Supperative Appendicitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acct. Peritonitis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemtery	Nov 28 1924
20-UNDERTAKER,	ADDRESS
Mrs Jas H. Dennis	303 Presstman St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Galoska

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92392

CERTIFICATE OF DEATH.

90 D 92392

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Galaska

(a) RESIDENCE No. 1606 Aliceanna St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record

(Address)

15 NOV 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25/24

17

I HEREBY CERTIFY, That I attended deceased from Oct 3 - 24 19.... to Nov 25 19 24, that I last saw h~~e~~ alive on 11/25/24 19.... and that death occurred, on the date stated above, at 12 40P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

Cardiac Paralysis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cholecystitis Cholelithotomy

Did an operation precede death? Yes Date of Oct 5-24

Was there an autopsy? Yes Drainage of Gall Bladder

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelly, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 28 1924
20 UNDERTAKER	ADDRESS
John A. Kelly	1803 Bay

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92393

CERTIFICATE OF DEATH.

90 D 92393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1477 W Lanvale ST., 23 WARD)

2-FULL NAME Winifred Jenney

(a) RESIDENCE NO. 1477 W Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caleb Jenney

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. Jenney (Address) 1478 Lanvale St

15 NOV 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 23 1924 to Nov 25 1924

that I last saw h[illegible] alive on Nov 25 1924

and that death occurred, on the date stated above, at 7 00 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Scheurich M. D.

(Address) 114 E. West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 11/28/1924

20 UNDERTAKER J. J. Fahey

ADDRESS 1318 Eighty

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

D 92394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92394

CERTIFICATE OF DEATH.

REGISTERED NO.

3-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rena Wagner

(a) RESIDENCE No. New Windsor ST., WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married -

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ A.W. Wagner

6 DATE OF BIRTH (month, day, and year) 1883 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adam W. Bloom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Mary A. Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant (Address) Hospital Records

Filed NOV 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 19 24, to Nov 28, 19 24.

that I last saw her alive on Nov. 28, 19 24,

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroids.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of (1) Nov. 20-1924 (2) Nov. 24 1924

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Anthony V. Buchneas, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Windsor Md — DATE OF BURIAL: Nov 30 1924

20 UNDERTAKER: L.H. Weimer — ADDRESS: New Windsor Md

information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92395

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Page

(a) RESIDENCE NO. Sparrow Point, ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Page Dead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alma Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records John Hopkins Hospital

Filed NOV 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1924. to Nov 26, 1924. that I last saw him alive on Nov 26, 1924. and that death occurred, on the date stated above, at 10 45 P.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Syphilis & Gonorrhea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/23/24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) ..... M. D.

(Address) Johns Hopkins Hospital

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Suffolk, Va

DATE OF BURIAL Nov 30 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Time of burial extended to Nov 30/24 V

D 92396

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

J. Frederick Hempel 25th Ward

REGISTERED NO. 92396

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Johnson

(a) RESIDENCE No. 1422 Orleans ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records

(Address)

15 Filed NOV 28 1924 ..... 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-1924

17 I HEREBY CERTIFY, That I attended deceased from 9-5-1924, to 11-25-1924

that I last saw ~~him~~ alive on 11-24-1924

and that death occurred, on the date stated above, at 2.40 a m.

The CAUSE OF DEATH* was as follows:

C.N.S Syphilis (General Paresis)

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sat. & Autopsy

(Signed) Claude C. Brace M. D.

11-25-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry Cemetery	Nov 30 1924
20 UNDERTAKER	ADDRESS 1631
Edward Bryon	Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92397

CERTIFICATE OF DEATH.

24 11-001

D 92397

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1439 Hull St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford J. Hartung

(a) Residence No. 1439 Hull St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) Oct 31-23

7-AGE. 1 yrs. 0 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John A. Hartung

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Emma Rickenbery

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) John A. Hartung

(Address) 1439 Hull St

NOV 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 26-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 19 24 to Nov 26 19 24

that I last saw h.. alive on Nov 26 19 24

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza & acute Otitis Media

(Duration) yrs. mos 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos J. Devins M. D

11/27 1924 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. — DATE OF BURIAL: Nov 28 1924

20-UNDERTAKER: Chas. L. Devins — ADDRESS: 3561 E Fort Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92398

CERTIFICATE OF DEATH. 129

D 92398

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 242 Forest St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stanley

(a) Residence No. 242 Forest St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Collord

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Driver 23

(b) General nature of industry, business, or establishment in which employed (or employer). 02

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Wm H Stanley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Amelia Ellett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Florence Desmond

(Address) 630 N Carrollton

15- Filed NOV 28 1924 ROBERT B. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 25, 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1924 to Nov 25 1924

that I last saw him alive on Nov 24 1924

and that death occurred, on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
1/2 Chronic Parenchymatous Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Johnny M D

11/26 1924 (Address) 1424 Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Asbury

DATE OF BURIAL. 11/28/24 19....

20-UNDERTAKER. R E Trost

ADDRESS 1405 McElderry St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48

D 92399

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 N. Bradford St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence A. Morrow

(a) Residence No. 1709 N. Bradford St. St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret J. Morrow

6-DATE OF BIRTH (month, day and year) Dec 8/78

7-AGE 45 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Henry Morrow

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto City

12-MAIDEN NAME OF MOTHER, Amanta R. —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto City

14-

(Informant) Margaret J. Morrow

(Address) 1709 N. Bradford St.

15- NOV 28 1924 ROBERT B. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 25/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1924 to Nov 25 1924

that I last saw h. alive on Nov 25 1924

and that death occurred, on the date stated above, at 2 35p m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Face

Lungs —

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) as to lungs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —,

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) J. W. Thomas M. D

Nov 26 1924 (Address) 1228 N. Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cem. DATE OF BURIAL, Nov 28, 1924

20-UNDERTAKER, Philip Herwig ADDRESS 2016 Orleans St.

In order to secure PROPER and UNIFORM classification, this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92400

D 92400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 E. Lanvale ST., 8 WARD)

2-FULL NAME Randall Fenton Hamnett Hammett

(a) RESIDENCE NO. 1903 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5th 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	15	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Hamnet Jr.

11 BIRTHPLACE OF FATHER (city or town) Normalytown (State or country) Pa.

12 MAIDEN NAME OF MOTHER Jessie Price

13 BIRTHPLACE OF MOTHER (city or town) Londonderry (State or country) Ireland

14 Informant John Hammett Jr. (Address) 1903 E Lanvale St

15 Filed NOV 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 .1924. to Nov 26 .1924.

that I last saw him alive on Nov 26 .1924.

and that death occurred, on the date stated above, at 4.05 P m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Heart Disease

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) Jno F Fisher M. D.

11/27 1924 (Address) 1823 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Dec 1st 24

20 UNDERTAKER Philip Henry

ADDRESS 2016 Adam St

mation should be carefully supplied. AGE. should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Michael

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92401

CERTIFICATE OF DEATH.

44 D 92401

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Colonial Hospital ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Michael

(a) RESIDENCE NO. 420 Saraden ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret G. Michael

6 DATE OF BIRTH (month, day, and year) Nov 5-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Peter H. Michael

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Rosl

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mildred Marquering
(Address) 420 Saraden St

15 Filed NOV 28 1924 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Novem. 10, 1924, to Novem. 25, 1924,

that I last saw him alive on Novem. 25, 1924,

and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of the Stomach

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory & autopsy.

(Signed) M. Alpert, M. D.

, 19 (Address) 2350 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 28 1924

20 UNDERTAKER J. B. Whipkirt ADDRESS 1850 N. Belto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 92402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92402

CERTIFICATE OF DEATH.

REGISTERED NO. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Westerwald ave ST.; WARD) 109-8C 10th Calvert 6 comm

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L Stewart

(Residence in Baltimore: No. 3313 Westerwald ave St.; 28 yrs., 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct (Month) 17th (Day), 1896 (Year)

7-AGE,	If LESS than 1 day,
28 yrs. 1 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

087

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm M. Stewart

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Cora Demling

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes M. Stewart

(Address) 3313 Westerwald ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11/27 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/26 1924, to 11/27 1924, that I saw h[illegible] alive on 11/27 1924, and that death occurred, on the date stated above, at 8:30a m.

The CAUSE OF DEATH* was as follows:

Edema of Throat

Pneumonia (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. ds.

(Signed) W C Cosad M. D.

11-27-24 (Address) Upton R.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Nov 29th 1924
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92403

CERTIFICATE OF DEATH.

179 D 92403

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 22 WARD)

2-FULL NAME Irene Hayes.

(a) RESIDENCE NO. 26 E. Hill St., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ---- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 26, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER William Hayes.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Indiana.

12 MAIDEN NAME OF MOTHER Zillia Bull.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Edith Smith (aunt)
(Address) 26 E. Hill St.

15 Filed DEC 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns about the body, while playing with matches

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Nov. 28, 1924 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Accident at 26 E. Hill St Nov. 25, 1924

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co — DATE OF BURIAL Nov 30 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+23 D 92404

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bradford S Brinkley

(a) RESIDENCE NO. College Park Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. / ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ernest H Brinkley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary D Stranghn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ernest H Brinkley
(Address) College Park Md

15 Filed NOV 28 1924 ROBERT R. KRAJTES, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Encephalitis

a Sunday

(duration) ..... yrs. ..... mos.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) T H Gorsuch, M. D.
(Coroner.)

11-28, 1924 (Address) 11 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn.

DATE OF BURIAL Nov 29 1924

20 UNDERTAKER Tom Cook.

ADDRESS 5-02 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92405

CERTIFICATE OF DEATH.

1924 D 92405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 23 WARD)

2-FULL NAME Herman Watkins Wesley

(a) RESIDENCE NO 903 Peach al ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Gen Lumber Co.
(c) Name of employer Mr. Lucas

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Herman Wesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER B. Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mamon Watkins
(Address) 164 Lemmon

15 Filed NOV 28 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot Pistol Wound

Homicide

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W F Farley, M. D.
(Coroner.)

Nov 26, 1924 (Address) 103 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov. 30 1924.

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92406

CERTIFICATE OF DEATH.

X 90 D 92406

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2449 N. Calvert St., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. West

(a) RESIDENCE NO. 2449 N Calvert ST., 12 WARD Glyndon Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice K. West

6 DATE OF BIRTH (month, day, and year) Nov 12-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~33~~	33		14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Standard Oil Co

9 BIRTHPLACE (city or town) Ind.
(State or country)

PARENTS

10 NAME OF FATHER Wm R. West

11 BIRTHPLACE OF FATHER (city or town) Ind.
(State or country)

12 MAIDEN NAME OF MOTHER Sara McFarland

13 BIRTHPLACE OF MOTHER (city or town) Shelbyville Ind.
(State or country)

14 Informant Alice K. West
(Address) 2449 N. Calvert St

15 Filed NOV 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows*:

Cerebral Disease
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Morrissey, M. D.
(Coroner.)

Nov 27, 1924 (Address) 1632 Rolandpark

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friend Burial Ground	Nov 29 1924
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler	1252 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 3

4 16 D 92407

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 660 W. Redwood St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Burrows

(a) Residence No..... St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, black

5-Single, Married, Widowed, or Divorced (Write the word.) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11-21-24

7-AGE, ... yrs. ..... mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John Burrows

11-BIRTHPLACE OF FATHER (city or town) (State or Country). S. Car.

12-MAIDEN NAME OF MOTHER. Edna Cooper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Edna Burrows

(Address) 660 W. Redwood St.

15- FILED NOV 28 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-25-24

17- I HEREBY CERTIFY, That I attended deceased from 11-21, 1924, to 11-25, 1924, that I last saw him alive on 11-25, 1924, and that death occurred, on the date stated above, at 7.20 A. m. The CAUSE OF DEATH* was as follows:

Hemophilia.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. Allen Novey M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Univ. of Md. DATE OF BURIAL, ..., 19....

20-UNDERTAKER ..... ADDRESS .....

UNIVERSITY OF MARYLAND

Bureau of Health,

Burial Permit Issued

NOV 28 1924

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159 D 92408

CERTIFICATE OF DEATH.

D 92408

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ... ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. 733 George St. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		Five	Three	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... MD

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Leroy Johnson

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha B. Dixon

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed NOV 28 1924 1988 Registrar

EMMA R. KRAUER
Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1924, to Nov 24, 1924, that I last saw her alive on Nov. 24, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus. ... 1 mo

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) E. L. Stone, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL ... 19

20 UNDERTAKER ... Commissioner of Health,

ADDRESS ... NOV 28 1924

For Wm. F. Wroth

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K-S-A

K O D A K

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 92409

D 92409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Tracy (Twin #2)

(a) RESIDENCE NO. 967 Pinney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			Two	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Tracy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Henrietta Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital

15 Filed , 19 1084 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/23, 1924, to 11/25, 1924,

that I last saw him alive on 11/25, 1924,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E L Stone, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL NOV 26 1924

NOV 28 1924

Dept. of Vital Statistics

Vital Records Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

360

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92410

CERTIFICATE OF DEATH.

D 92410

161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 1 WARD)

2-FULL NAME Baby Tracy (Twin # I)

(a) RESIDENCE No. 907 Binney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1924

7 AGE: Years | Months | Days: Two | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Tracy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Henrietta Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed , 19 1983 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/23, 1924, to 11/25, 1924,

that I last saw him alive on 11/25, 1924,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E L Stone, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

NOV 28 1924

Commissioner Health,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92411

CERTIFICATE OF DEATH.

90 D 92411

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2840 W. North ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary W. Herlihy

(Residence in Baltimore: No. 2840 W. North ave St.; 63 yrs. 01 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct (Month) 10th (Day), 1861. (Year)

7-AGE, 63 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City Maryland

PARENTS.

10-NAME OF FATHER, Samuel A Hobbs

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Mary Weddle

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Herlihy

(Address) 2840 W. North ave

15- NOV 28 1924 ROBERT R. KRAUTER, Registrar.

Filed, ... 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1919, to Nov 1924, that I saw her alive on Nov 25th 1924, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 5 yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Heart Asthenia Hemorrhage

(Duration) ..... yrs. 1 mos. 4 ds.

(Signed) A. B. Carcoche M. D.

Nov. 26th, 1924 (Address) 1802 Pleasant ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudenschlager — DATE OF BURIAL, Nov. 29 1924

20-UNDERTAKER Martin Funeral Home — ADDRESS 1822 N. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92412

CERTIFICATE OF DEATH.

X 100-001 D 92412

1-PLACE OF DEATH

CITY or BALTIMORE: (No 830 Ralong st ST., 18 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Ross

(a) RESIDENCE. No. 830 Ralong st ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State) Wash. D.C.

Length of residence in city or town where death occurred ..... yrs. 2 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) .....

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) .....

14 Informant ..... (Address) .....

NOV 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/24 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1924, to Nov 26, 1924, that I last saw h[illegible] alive on Nov 26, 1924, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Marcellus E. Toney, M. D.

19 (Address) 1745 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel, Cy.	Mar 28 1924
20 UNDERTAKER	ADDRESS
Leonard Wollen	677 Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21—E.B.R.S.—400 Bks.

D 92413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92413

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5229 Park Heights Av St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John Thomas Saddler

(a) Residence No. 5229 Park Heights Av St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. Saddler

6-DATE OF BIRTH (month, day and year) Sept. 7–1869

7-AGE, 55 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bicycle Mfr

(b) General nature of industry, business, or establishment in which employed (or employer) Bicycles

(c) Name of employer Self

9-BIRTHPLACE (city or town) (State or Country), Wash. D C.

PARENTS.

10-NAME OF FATHER, John W. Saddler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wash DC

12-MAIDEN NAME OF MOTHER, Virginia Lanham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Wash DC

14- (Informant Mrs Emma M. Saddler)

(Address) 5229 Park Hgts Ave

15- Filed NOV 28 1924 19.. ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 27. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 27, 19 24 to Nov 27, 19 24

that I last saw him alive on Nov 27 19 24

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

~~Cardiac Sclerosis~~

Chronic Endocarditis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Syncope

(Duration) Suddenly yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Ensor M. D.

11-27. 1924 (Address) 5106 Park Heights Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL. Dec 1 1924

20-UNDERTAKER. Harry W. Ehlen ADDRESS 1944 W. Nor. Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92414

CERTIFICATE OF DEATH.

3 2 D 92414

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Zellick

(a) RESIDENCE NO. House of Good Shepherd

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
15				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None 000

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Zulick

11 BIRTHPLACE OF FATHER (city or town) Do not Know
(State or country)

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town) Do not Know
(State or country)

14 Informant Hospital Record
(Address)

15 Filed ..... 19.... ROBERT R. KRAUTER, Registrar
NOV 28 1924
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/24 19

17

I HEREBY CERTIFY, That I attended deceased from 11/24/24, 19...., to 11/27/24 19 ,

that I last saw h[illegible] alive on 11/27/24 19 P.

and that death occurred, on the date stated above, at 10.32 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted D
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Foley, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md

DATE OF BURIAL 11/28 1924

20 UNDERTAKER J. J. Foley & Sons

ADDRESS 318 Light St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Cairnes)

D 92415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 100-001 ✓ D 92415

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs George R Cairnes

(a) RESIDENCE NO. Belair, Md, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs George R. Cairnes

6 DATE OF BIRTH (month, day, and year) Sept. 7- 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Business

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Mr George Cairnes

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bay.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Miss Cairnes
(Address) Belair Md

15 Filed NOV 28 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 22, 1924, to Nov 28, 1924, that I last saw him alive on Nov 28, 1924 and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Prostatectomy performed for obstruction to passage of Urine

Prostatic Hypertrophy with Obstruction

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Belair, Md.

Did an operation precede death? yes Date of Nov. 15, 1924.

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Raymond T. Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemy Hartford Co | DATE OF BURIAL: Dec 6 1924

20 UNDERTAKER: Dean & Foster | ADDRESS: Belair Md

THIS IS A PERMANENT RECORD. Every item on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D 92416

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1206 Wilcox St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Guerin

(a) Residence No. 1206 Wilcox St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 1 1924

7-AGE. ..... yrs. 11 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER William J. Guerin

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Sarah M. Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) William J. Guerin

(Address) 1206 Wilcox St.

15- Filed NOV 28 1924 16- Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). NOV 27 1924

17- I HEREBY CERTIFY, That I attended deceased from NOV 25 1924 to NOV 27 1924

that I last saw h. l. M. alive on NOV 27 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
and a general toxemia
after Croup? of 5 days
(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Laryngeal Diptheria
(Duration) X yrs. X mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of X X

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological examination

(Signed) A. H. Dukes M. D

(Address) 928 6 North Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Cathedral	Nov 29 1924
20-UNDERTAKER.	ADDRESS
E. A. Wingfield Jr	5016 22 St

Should be carefully supplied. AGE Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Will call after two in the morning

D 92417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 92417

1-PLACE OF DEATH

City of BALTIMORE: (No. 2314 Taylor St 9 Ward) Registered No.....

2-FULL NAME..... Ferdinand Meitz

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2314 Taylor St Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Helena Bunk

6-DATE OF BIRTH (month, day and year) May 3-1856

7-AGE, 68 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Adam Meitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amelia Selnert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Helena Meitz

(Address) 2314 Taylor St.

15- Robert F. Harrison, Dr pro Fisher

Filed....., 192.....

12 Oct 1924 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 26-24

I HEREBY CERTIFY, That I attended deceased from Nov 25, 192X to Nov 26, 192X

that I last saw him alive on Nov 26, 192X

and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

11/28, 1924 (Address) 1823 N. Wood St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn | DATE OF BURIAL, Nov. 29, 1924

20-UNDERTAKER, H. C. Wiedefeld | ADDRESS 914 Greenmt Av

Instructions: Fill out completely. Answers should be written in ink, plainly. Copy supplied. Any wording be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92418

CERTIFICATE OF DEATH.

170 D 92418

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Weber

(a) RESIDENCE No 105 N. Castle St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): July 16/1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Julius Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Freidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Julius Weber
(Address): 105 N. Castle St

15 Filed: NOV 28 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage- pistol shot wound in rt. temple-sulcide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Fallon, M. D.
(Coroner.)
11/28/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 29 1924
20 UNDERTAKER	ADDRESS
Kendell Dippel Son	314 Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92419

CERTIFICATE OF DEATH.

90 D 92419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Harford Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Raymond

(a) RESIDENCE NO 1712 Harford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widowerd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Late) Margaret Raymond

6 DATE OF BIRTH (month, day, and year) March 2/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Bubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Frank Kohlman (Address) 1712 Harford Ave

15 Filed 11 28 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility- arteriosclerosis

(duration) yrs. mos. ds.

(Signed) [signature] (Coroner.), M. D.

11/28/24, 192 (Address) 300 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL 11 28 1924

20 UNDERTAKER George J Ruth & Co ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 92420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard r Green ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lawton

(a) RESIDENCE No. 36 Annapolis Ave ST. Mt. Winans WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Georgia Lawton

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Martin Lawton

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Hanna Hallman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Georgia Lawton

(Address) 36 Annapolis ave

NOV 28 1924

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Sep. 23, 1924, to Nov. 27, 1924, that I last saw h~~im~~er alive on Nov. 27, 1924, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) General carcinomatosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of Nov. 10.

Was there an autopsy? no.

What test confirmed diagnosis? operation

(Signed) M Edwards, M. D.

, 19 (Address) University Hospital Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ave	11-29-24
20 UNDERTAKER	ADDRESS 916
Bond Easton	Eo ave

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every effort of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92421

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette & Payson ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Genevieve Schroeder

(a) RESIDENCE No. 401 South Norris ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Schroeder

6 DATE OF BIRTH (month, day, and year) May 26 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Lemar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catharine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm Schroeder

(Address) 401 S Norris St

15 NOV 28 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1924, to Nov. 26, 1924, that I last saw her alive on Nov. 26, 1924, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clin. & Lab. Tests

(Signed) Hm Powell, M. D.

11/26/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem — DATE OF BURIAL 11/29 24

20 UNDERTAKER Geo A Farley Fulton Fayette — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Nettie L. Cermak)

HEALTH DEPARTMENT—CITY OF BALTIMORE

175-884 D 92422 — X84 D 92422

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie L. Cermak

(a) RESIDENCE NO. St Petersburg Fla ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 28 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wilhelm Cermak

6 DATE OF BIRTH (month, day, and year) May 12 - 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mich

PARENTS

10 NAME OF FATHER Frank Liska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Matilda Kaluck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant (Address) Records Johns Hopkins Hospital

15 Filed NOV 28 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1924, to Nov 28, 1924 that I last saw her alive on Nov 28, 1924, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aspiration Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Fla.

Did an operation precede death? Yes Date of Nov 14 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield Interne, M. D.

, 19 (Address) Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cleveland Ohio	Nov 28 1924
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W Saratoga

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Norton, 888 N Lombard St

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92423

CERTIFICATE OF DEATH.

179

D 92423

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 West Vine ST., 20 WARD)

2-FULL NAME Mary J Trogler

(a) RESIDENCE NO. 2104 West Vine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Trogler

6 DATE OF BIRTH (month, day, and year) Sept 9. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Allen Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary E Chem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mary E Corbin
(Address) 2104 W Vine St

15 Filed 12 8 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16th, 1924, to Nov. 26, 1924, that I last saw her alive on Nov. 26th, 1924, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) None.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis etc.

(Signed) T. Norton, M. D.

11/27, 1924 Address 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 29 1924
20 UNDERTAKER W. Cook	ADDRESS 502 E Lexington

mation should be carefully supplied. AGE sho... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See instructions on ba...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92424

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 B 92424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 W 36 St. 13 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Roller

(a) RESIDENCE. NO. 901 W 36 St. 13 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Geo L Roller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sydney Hunper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Mrs Geo Roller Same

15 Filed NOV 29 1924 Robert E. Griffin Registrar

NOV 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-24 1924, to 11-27 1924, that I last saw him alive on 11-26 1924, and that death occurred, on the date stated above, at 9. a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Cystitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C Humbert, M. D.

1127 1924 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Valley Westminster	Nov 29 1924

20 UNDERTAKER Ehenoweth Son ADDRESS 3617 Chestnut Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Bks.

D 92425

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-901 ✓ D 92425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hosp. Registered No.....

City of BALTIMORE: (No. Elmwood St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Dobrzycki (or Jarnicki

(a) Residence No. 2200 Cambridge St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William Trzcinski

6-DATE OF BIRTH (month, day and year) July 10 1890

7-AGE. 34 yrs. 4 mos. 18 ds. OR LESS than 1 day. hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mr William Trzcinski

(Address) 2200 Cambridge

15- Filed NOV 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1924, to Nov. 27, 1924, that I last saw h. alive on Nov. 27, 1924, and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. B. Sybert, M. D.

, 19 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov. 29, 1924
20-UNDERTAKER, John McWeber	ADDRESS 1803 Bank

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92426

CERTIFICATE OF DEATH.

X 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2532 Eager Place ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances W. Miles

(a) RESIDENCE No. 2532 Eager Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4-1924

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	23.	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Capital Heights Md.

PARENTS

10 NAME OF FATHER Edgar S. Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marjorie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Edgar S. Miles (Address) 2532 Eager Place

15 Robert F. Harrison, Registrar

V2 9 1924 .19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-15 .19 24. to 11-27 .19 24.

that I last saw her alive on 11-27 .19 24,

and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 3 mos 23 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 11-10-24

Was there an autopsy? No

What test confirmed diagnosis? Operation at John Hop.

(Signed) Daniel Miles, M. D.

.19 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. | DATE OF BURIAL: Nov 29 1924

20 UNDERTAKER: Geo. M. Fink & Son | ADDRESS: 811 N. Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 92427 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161001 D 92427

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 437 W Hennetta St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Princess

(a) Residence No. 437 W Hennetta St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male | 4-COLOR OR RACE, Col | 5-Single, Married, Widowed, or Divorced, (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 11/27/24

7-AGE. — yrs. — mos. — ds. | If LESS than 1 day, 3 hrs. or — min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Premature Birth
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Maryland

PARENTS.
10-NAME OF FATHER, Ernest Princess
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Winnsboro S. Carolina
12-MAIDEN NAME OF MOTHER, Willie Boyd
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Winnsboro S. Carolina

14-
(Informant) Ernest Princess
(Address) 437 W Hennetta

15-
Filed NOV 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/28/24

17- I HEREBY CERTIFY, That I attended deceased from 11/27, 19 24 to 11/28, 19 24 that I last saw h— alive on 11/27, 19 24 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth
Pregnancy 6½ mo.
" Maternal fall down stairs "

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Dr. Jamison M. D.

11/28, 19 24 (Address) 1111 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, 19

20-UNDERTAKER, Commissioner Health, ADDRESS

Per Wm. E. Woodall. NOV 28 1924

IMPORTANT: Cause of death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92428

CERTIFICATE OF DEATH.

D 92428

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy Brown.(C).

(a) RESIDENCE NO. 701 Hanover Street. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) April 19, 1904.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	7	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Robert Brown.(C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Turpin.(C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Virginia Robinson.(C)(sister)
(Address) 701 Hanover Street.

15 Dated NOV 29 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purulent peritonitis due to a bullet wound in the abdomen.

Homicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Bernhardt, M. D. (Coroner.)

Nov. 28th, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Shot at Hamburg & Howard Sts. Nov. 1st, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Glen Cl	Nov 30 1924
20 UNDERTAKER	ADDRESS
S. S. Brown & Son	1084 W. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 S. Garrison Lane ~~St~~ WARD) 70

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Conrad

(a) RESIDENCE NO. 130 S. Garrison Lane ~~St~~ WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Miller Conrad.

6 DATE OF BIRTH (month, day, and year) July 25-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Berlin (State or country) Germany.

PARENTS

10 NAME OF FATHER ? Conrad

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany.

12 MAIDEN NAME OF MOTHER ? Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany.

14 Informant Lena Conrad. (Address) 130 S. Garrison Lane.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 27 1924

17

I HEREBY CERTIFY, That I attended deceased from November 22, 1924, to November 27, 1924, that I last saw him alive on November 27, 1924, and that death occurred, on the date stated above, at 4:55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemmorhage.

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Chester Riland, M. D.

11-27 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92430

CERTIFICATE OF DEATH.

38 D 92430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp St. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Holmes

(a) RESIDENCE No. 210 So Fulton ave St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs E Holmes

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or ..... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: Andrew Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Mrs Erickson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Mrs Louisa Holms

(Address) 210 S. Fulton Ave

15 Filed NOV 29 1924, 19 Robert F. [illegible] Registrar

Burial Permit 61

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-1924

17

I HEREBY CERTIFY, That I attended deceased from 11-25, 1924, to 11-28-, 1924, that I last saw him alive on 11-28, 1924, and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary): Cures.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Monninger M. D.

11-28, 1924 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 1 1924

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Howe

(a) RESIDENCE No. 3017 Pennsylvania Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Howe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Allen Boardman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant (Address) Records Johns Hopkins Hospital

15 Filed Nov 29 1924 Robert T. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924, to Nov 28, 1924, that I last saw h... alive on Nov 28, 1924, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Grahm, M. D.

(Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 1 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

V 29 1924

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92432 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92432

1394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 113 South St ST., 25 WARD)

REGISTERED NO. 100-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Zawistowski

(a) RESIDENCE NO. 113 Lloyd St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Zawistowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Gregoch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Hopkins Hospital

Filed NOV 29 1924, 19 ROBERT P. HARRISON, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1924, to Nov 28, 1924,

that I last saw h... alive on Nov 28, 1924,

and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Inanition (See other side)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

Where was disease contracted if not at place of death? Hosp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund A. Kerper, M. D.

11/28, 19 24 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	Nov 29 1924
20 UNDERTAKER	ADDRESS
Stephen L Fialkowski	1005 Kinsworth

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92433

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 N. Milton ave ST., 6 WARD)

2-FULL NAME James J Black house

(a) RESIDENCE No. 1633 N. Milton ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola Wells Black house

6 DATE OF BIRTH (month, day, and year): Apl 3-1850

7 AGE: Years 74 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Builder

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

PARENTS

10 NAME OF FATHER: Jobild J Black house

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Emily Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Viola Wells Black house

(Address) 1633 N. Milton ave

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1924, to Nov 27 1924.

that I last saw him alive on Nov 27 1924

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Mitral Regurgitation)

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) D P Herzog M.D. M. D.

(Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Nov 29 1924

20 UNDERTAKER: Robt F Turner Inc — ADDRESS: 1 N Howard

12 9 1924 Burial Permit Clerk

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH CARBON INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92434

CERTIFICATE OF DEATH.

161 D 92434

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2089 Windsor Av ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Miller

(a) RESIDENCE. No. 2089 Windsor Av ST. 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11-28-24

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.
	0	0	0	1½ hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Calvin E Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Lulu Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Calvin Miller
(Address) 2089 Windsor

15 Filed . . 19 . . Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-28 1924 to 11-28 1924.
that I last saw h alive on 11-28 1924.
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:

Premature Gestation

0 0 0
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) E Friedgood M. D.

11-29 1924 (Address) 2101 Riley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Nov 29 1924

20 UNDERTAKER Chenworth Son ADDRESS 3677 Chestnut Ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92435

HEALTH DEPARTMENT—CITY OF BALTIMORE

92435

CERTIFICATE OF DEATH.

118-005

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2901 E. Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Doran

(a) Residence No. 2901 E. Monument Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Florence Burgunder

6-DATE OF BIRTH (month, day and year) Apr. 4 1889

7-AGE. 35 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Stewart Taft
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Co., Md

PARENTS:
10-NAME OF FATHER, Patrick Doran
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Fannie Baker
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Co. Md

14- (Informant) Mrs. Doran
(Address) 2901 E. Monument

15- Filed ..... 192 Robert P. Harrison, Registrar.

NOV 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 28 R 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 d, 1924 to Nov. 28 d, 1924

that I last saw h[im] alive on Nov. 28 1924

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Shock due to
Obstruction in Intestine

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Obstructed Bowel

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William Dew M. D

19 (Address) 2901 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	Dec. 1, 1924
20-UNDERTAKER, Margaret F. Flynn	ADDRESS 1422 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92436

1-PLACE OF DEATH

City of BALTIMORE: (No. Virginia Ave Raspeburg St., 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lydia M Balster

(a) Residence No. Virginia Ave Raspeburg Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ Married ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo D. Balster

6-DATE OF BIRTH (month, day and year) Feby 12-1884

7-AGE. 40 yrs. 9 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of Industry, business, or establishment in which employed (or employer). 137

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Enbles

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Dont Know

14-(Informant) Geo D. Balster

(Address). Virginia Ave Raspeburg

15-Filed Nov 28 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 27/1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 31 — 1924, to Nov 27 1924, that I last saw h.. alive on Nov 27 1924, and that death occurred, on the date stated above, at 5.05 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis - (Hemiplegia Left

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Coma —

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Wm A Brandt, M. D.

Nov 28. 1924 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel — DATE OF BURIAL. Nov 29 1924

20-UNDERTAKER. John Ulrich — ADDRESS 208 Orleans

V2 9 1924

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 D 952 HEALTH DEPARTMENT—CITY OF BALTIMORE 29D 92437

17D 92437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Jane E. Lowe

(a) RESIDENCE No. 944 N Bond St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Field Secretary

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER: Solomon Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Sally Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant (Address): Records John Hopkins Hospital

15 Robert P. Harrison, Registrar

12 9 1924 19 Imperial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1924 to Nov 22, 1924.

that I last saw her alive on Nov 24, 19 ,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension, chronic nephritis & myocardial insufficiency

(duration) 1 yrs. + mos. + ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Prob. Wheeling W. Va

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Manfred Guttmacher, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wheeling W. Va — DATE OF BURIAL: Nov 24, 24

20 UNDERTAKER: John H. Jordan — ADDRESS 1037 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92438 D 92438

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 824 S. Sharp St. 22 Ward) Registered No.....

2-FULL NAME Eliza Truitt (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 824 S. Sharp St. 22 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Col'd

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Truitt

6-DATE OF BIRTH (month, day and year) May 27 1870

7-AGE. 54 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Today Helper

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Robert H Maddox

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Harriett Bailey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Mrs. Minnie Jackson

(Address) 824 S Sharp St

15- Filed NOV 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11/28/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 5th 1924 to 11/28/24 in that I last saw h... alive on 11/25/24 and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Psoas Abscess

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Doc

Carcinoma (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

11/28/24 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL, Nov 30 1924

20-UNDERTAKER. John H. Toadvine — ADDRESS 1027 Druid Hill Ave

In order to be legally supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter on file Nov 29-1924 from Claude Davenport MD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92439

CERTIFICATE OF DEATH.

101-001 ✓ D 92439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 4 WARD)

2-FULL NAME Mary Davenport

(a) RESIDENCE NO. 702 Josephine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883 ~~1876~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41 ~~45~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: James Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Municipal Hospital Records

(Address)

15 V2 9 1924 .... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-24, 1924, to 11-26, 1924, that I last saw her alive on 11-26, 1924 and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Lab. + Autopsy

What test confirmed diagnosis?

(Signed) Claude A. Davenport, M. D.

11-27, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 19 1924

20 UNDERTAKER: Edward P. Kenealy — ADDRESS: 728 N Eddle

R. F.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Johnson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92440

CERTIFICATE OF DEATH.

D 92440

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Johnson

(a) RESIDENCE NO 1043 N Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Johnson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Geo Whittington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emily Redfoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: James Johnson (Address) 1043 N Saratoga St

15 Filed Nov 29 1924, 192 ROBERT P. HARRISON, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fibroid Lobulated Intramural

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

Nov 29, 192 (Address) 1039 Bun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fort Deposit Md

DATE OF BURIAL: Nov 30 1924

20 UNDERTAKER: Samuel Hemsley

ADDRESS 578 W Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92441 HEALTH DEPARTMENT—CITY OF BALTIMORE

176 39 CERTIFICATE OF DEATH. X 46 D 92441

1-PLACE OF DEATH John Hopkins Hosp REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Sands

(a) RESIDENCE NO. 2304 Mc Culloh St WARD Essex Co. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Thomas Sands

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
63	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Edward Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah Keith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Dispy John Hopkins Hosp

15 Filed NOV 29 1924, 19 Robert V. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924 to Nov 23, 1924

that I last saw her alive on Nov 23, 1924

and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovaries,
General Carcinosis
Ascites

(duration) yrs. 0 mos — da.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 11/24/24

Was there an autopsy? yes

What test confirmed diagnosis? Operation & autopsy

(Signed) George H. Gardner M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Del. DATE OF BURIAL: Nov 29 1924

20 UNDERTAKER: Samuel Kennedy ADDRESS: W Dedd

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

176268 92442

CERTIFICATE OF DEATH.

139 D 92442

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Phillips

(a) RESIDENCE No. 1368 Penn Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Percell Phillips

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER Thomas Bumbrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Elizabeth Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Percell Phillips Record, Percell Phillips Robert F. Harrison,

15 Filed NOV 29 1924 19 Burial Permit Clerk, Registrar G.S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1924, to Nov 26, 1924, that I last saw her alive on Nov 26, 1924, and that death occurred, on the date stated above, at 7:10 p m.

The CAUSE OF DEATH* was as follows:

Peritonitis, streptococcic
Cellulitis of Wound

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myomata Uteri - Subperitoneal streptococcic (duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 11/22/24

Was there an autopsy? yes

What test confirmed diagnosis? autopsy operating

(Signed) George H. Gardner, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic [illegible] — DATE OF BURIAL: Nov 29 1924

UNDERTAKER: Samuel Hemsley — ADDRESS 1728 N Eutaw St.

...mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92443

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D 92443

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 W Lexington ST., 20 WARD)

2-FULL NAME John P Mc Hugh

(a) RESIDENCE (No. 2113 W Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
33	33	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER James Mc Hugh

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Coady.

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Jas Mc Hugh
(Address) 2113 W Lexington

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1924, to Nov 27, 1924, that I last saw him alive on Nov 27, 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about 3
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia Convulsions

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Hattie E Tuchayian M. D.

Nov 29, 1924 (Address) 2302 W Lex. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 12/1 24

20 UNDERTAKER Enoch Staley Fulton & Forgette — ADDRESS .....

NOV 29 1924 Robert P. Harrison,
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K·O·D·A

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92444

CERTIFICATE OF DEATH.

D 92444

Registered No. 49

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1227 N Caroline St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theodore Overdeck

(a) Residence No. 1227 N Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Annie Graf

6-DATE OF BIRTH (month, day and year) May 3 1864

7-AGE. 60 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Jewelry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 1387

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Ceaj

PARENTS.

10-NAME OF FATHER, Aug Overdeck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Annie Overdeck

(Address) 1227 N Caroline

15- Filed NOV 29 1924 19.. Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1924 to Nov 27 1924

that I last saw h.. alive on Nov 27 1924

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Chronic Cons

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. W. Bernard M. D.

Nov 28 1924 (Address) 1226 E Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western — DATE OF BURIAL, 11/29, 1924

20-UNDERTAKER. E J Fanning & Son — ADDRESS 1938 E Lafayette

NOV 29 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92445

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 DeHenry Court ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Ed. Jordan

(a) RESIDENCE NO. 1706 DeHenry Court ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 28, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Jordan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Newman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Mary E. Jordan
(Address) 1706 DeHenry Court

15 Filed ..... 1924 Robert P. Harrison, Registrar

11 29 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremic Coliki

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Nov. 28, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. A. Suburb	Nov 29 1924
20 UNDERTAKER Wm. H. Brasel Sons	ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Croft

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 92446

+ 90 D 92446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hotel Cromwell ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. V. Croft

(a) RESIDENCE NO 163 Lafayette Ave. Brooklyn N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 72nd Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	60 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Eng. N. York.
(State or country)

10 NAME OF FATHER Thos. Crofts

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (city or town)
State or country)

Informant Chas. Crofts
(Address) N. York

Filed NOV 10 1924 ROBERT R. KRAUTER
Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29th 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner McCoy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cardiac Asthma

Chronic Valv. dis. Heart

(duration) about 1 yr 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)
Nov 29, 192 (Address) 163 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City, N.Y.	11/30/1924

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette Ave. ADDRESS

N. B.—Every item of information should be carefully stated EXACTLY. PHYSICIANS should state state CAUSE OF DEATH in plain terms. Exact statement of OCCUPATIONS on back of certificate. is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. Should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-

Spec—12-23-2:—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92447 CERTIFICATE OF DEATH. 38 D 92447

1-PLACE OF DEATH Boylan View Hospital 6 Registered No.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Blake

(a) Residence No. 15 N. Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1871

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), do

12-MAIDEN NAME OF MOTHER, do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), do

14-Informant Boylan View Hospital

(Address)

15-Filed NOV 30 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 27 1924

I HEREBY CERTIFY, That I attended deceased from Oct. 4 1924 to Nov. 27, 1924

that I last saw h alive on Nov. 27 1924

and that death occurred, on the date stated above, at 10.35 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) General Paralysis.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Were findings confirmed by clinical findings

What test confirmed diagnosis?

(Signed) H. H. Aquith M. D.

11/28 1924 (Address) Boylan View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL, November 30 1924

20-UNDERTAKER. Inv R A Elliott — ADDRESS 1735 Ashland Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92448

CERTIFICATE OF DEATH.

D 92448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. East at Rear Barnes St., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Harris

(a) RESIDENCE NO. 369 N Exeter ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fabric
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) ..... Va.
(State or country)

PARENTS

10 NAME OF FATHER Miles Harris

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Thomas Harris
(Address) 1107 McCulloh

15 Filed NOV 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 192 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Nov. 29, 192 4 (Address) 1679 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
Laurel Cemetery	
20 UNDERTAKER	ADDRESS
Chas. H. Jolly	46 N. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 92449

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mc Gaw Place St., 13 Ward)

2-FULL NAME Mrs Rebecca Rothman.

(a) RESIDENCE NO. 748 N. Monroe St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Rothman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Joseph Meinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Rebecca Rothman 748 N Monroe St

15 Filed . 19 . ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-24

17 I HEREBY CERTIFY, That I attended deceased from 11-15-24, 19 , to 11-29-24, 19 , that I last saw her alive on 11-29-24, 19 , and that death occurred, on the date stated above, at 3 05 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Septicemia

(duration) yrs. 2 mos 20 ds.

CONTRIBUTORY (Secondary) Uremia, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home?

Did an operation precede death? Yes Date of 11/15/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mash Road DATE OF BURIAL 11-30 19 24

20 UNDERTAKER Jack Lewis ADDRESS 1409 E Baltimore

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92450

CERTIFICATE OF DEATH

101-001 D 92450

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2005 Ruxton ave St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Sachs

(Residence in Baltimore: No. 2005 Ruxton ave St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Aug — (Month) (Day), 1894 (Year)

7-AGE: 30 yrs. 3 mos. ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore City Md

PARENTS

10-NAME OF FATHER: Isaac Goldstein

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Celia —

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Lewis

(Address) 1439 E Balto St

NOV 30 1924

Filed ....., 191.... ROBERT B. KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 28th, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21st, 1924, to, Nov 28th 1924, that I saw h— alive on Nov 24th 1924, and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. J. Sanken M. D.

11/28th, 191.. [Address] 119 N. Milton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Sharon Rest Park

DATE OF BURIAL: 11-30, 1924

20-UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92451

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5031 Denmore ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Rochstein

(a) RESIDENCE. NO. 5031 Denmore ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Rochstein

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Frank Gusovsk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Lasch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Rochstein
(Address) 5031 Denmore ave

15 Filed NOV 30 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1924.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1924, to Nov. 28, 1924, that I last saw h alive on Nov. 28, 1924, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

(1) Cerebral Hemorrhage.

(2) Malignant endocarditis.

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination.

(Signed) Charles S. Nuntsdt, M. D.

11/29 1924 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrer Mt Zion	11/30 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92452

CERTIFICATE OF DEATH.

100-001 D 92452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. No. 13 Rosemont Ave ST., 27 WARD)

2-FULL NAME Margaret B. Elgel.

(a) RESIDENCE NO. 13 Rosemont Ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 21 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or min.
	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph J. Elgel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A Swindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Joseph J. Elgel

(Address) 13 Rosemont Ave

15 Filed NOV 30 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1924, to Nov 28, 1924, that I last saw her alive on Nov 28, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: "

Pneumonia Broncho

From Nov 25 to 28th

Following. Jaundice Probably

Hemolytic (duration) and Acute Bronchitis

CONTRIBUTORY (Secondary) from Nov 17th to 28th

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G Webster M. D.

(Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — DATE OF BURIAL: Dec. 1 1924

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Eager

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92453

CERTIFICATE OF DEATH (Evans)

101-001 D 92453

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Orkney Road ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Park Stebb

(a) RESIDENCE No. 514 Orkney Road Evans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced. HUSBAND of (or) ~~WIFE~~ of Isabelle Stebb

6 DATE OF BIRTH (month, day, and year) Dec. 10 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Port Deposit Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. John J. Geraghty

(Address) 514 Orkney Road (Evans)

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/23, 1924, to 11/29, 1924, that I last saw h. alive on 11/29, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dr Bernard Wells, M. D.

11/30, 1924 (Address) 914 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cemetery Ellicott City Md. DATE OF BURIAL Dec. 2 1924

20 UNDERTAKER Henry Storck Son ADDRESS 1301 E Fayette St.

NOV 3 1925 INGEL P. KRAUTER

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92454

CERTIFICATE OF DEATH.

D 92454

1-PLACE OF DEATH

City of BALTIMORE: (No. 1130 Hanlicker St., 21 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James Higdon

(a) Residence No. 1130 Hanlicker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If ~~married~~, widowed, or ~~divorced~~, HUSBAND of (or) ~~WIFE of~~ Anna R. Higdon

6-DATE OF BIRTH (month, day and year) May 30-1844

7-AGE. 80 yrs. 2 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Thomas Higdon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Joseph Higdon

(Address) 1130 Hanlicker St

15- Filed NOV 26 1924, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 25-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 2, 19.24, to Nov 25, 19.24, that I last saw h— alive on Nov 25, 19.24, and that death occurred, on the date stated above, at 4.10 P.M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Le Grippe

(Duration) — yrs. — mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gruenke, M. D.

11/29, 19.24 (Address) 617 Lodor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL, DEC 1 1924

20-UNDERTAKER, Geo W Little — ADDRESS 2100 EDMONDSON AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92455
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D 92455
Registered No.....

City of BALTIMORE: (No. 1101 S. Kenwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bronislawa Wesniewska

(a) Residence No. 1101 S. Kenwood Ave St., 1 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 11 Known 1874

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Ignacy Wesniewski
(Address) 1101 S. Kenwood Ave

15-
Filed NOV 30 1924 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). NOV-28-24

17- I HEREBY CERTIFY, That I attended deceased from November 25 1924 to Novemb 25 1924 that I last saw h[illegible] alive on Nov. 28 1924 and that death occurred, on the date stated above, at 1.55 p m.

The CAUSE OF DEATH* was as follows:
Bronchial Asthma

(Duration) 1 yrs. 6 mos. 12-10-24 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bronshvar M. D

11-30-1924 (Address) 3037 O'Donnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem	Dec 1 1924
20-UNDERTAKER.	**ADDRESS**
Stephen J Fialkowski	1100 Kenwood Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Coyle.

92456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 212 London Ave. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Coyle Sr.

(a) Residence No. 212 London Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 27 1871

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Branfinisher.

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Bucks Co Pa.

PARENTS.

10-NAME OF FATHER Patrick Coyle.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Mary Hayes.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14- (Informant) John J Coyle Jr.

(Address) 212 London Ave.

15- Filed NOV 30 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 27/1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1924 to Nov 27 1924

that I last saw h— alive on Nov 27 1924

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical Findings

(Signed) W. A. Knell M. D

11/30/24 19 (Address) Long Lane

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. 1924

20-UNDERTAKER, E. A. Winefield ADDRESS 501 E 22 St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92457

CERTIFICATE OF DEATH.

10

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 622 Fair Oak St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Marie Blackburn

(a) Residence No. 622 Fair Oak St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 20 1917

7-AGE. 7 yrs. 10 mos. 9 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Willard Blackburn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Marie Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Willard Blackburn

(Address) 622 Fair Oak

15- Undertaker.

Filed NOV 30 1924 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1924 to Nov 29 1924

that I last saw h alive on Nov 29 1924

and that death occurred, on the date stated above, at 9:40 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. L. Campbell M. D.

Nov 29 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL, Nov 30 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92458

CERTIFICATE OF DEATH.

100-001

D 92458

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 Indiana Av St., 25 Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Caroline Kirchner

(a) Residence No. 606 Indiana Av St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of August

6-DATE OF BIRTH (month, day and year) June 17, 1843

7-AGE. 81 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Joseph Kirchner

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Emily Kuhn

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant) Anna K. Boyle
(Address) 606 Indiana Ave

15-
Filed..... 192.....
Burial Permit Issued
Registrar.

NOV 30 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 19 24 to Nov 30 19 24
that I last saw h.er alive on Nov 29 19 24
and that death occurred, on the date stated above, at 7-10 a m.
The CAUSE OF DEATH* was as follows:

Bronchial asthma

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 11 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. S. Mkieffer M. D
Nov 30, 1924 (Address) 2320 Hoad Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Dec 1 5 1924
20-UNDERTAKER,	ADDRESS
Wm Cook Sons & Co.	

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92459
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. D 92459

City of BALTIMORE: (No. Edgewood ~~Avenue~~ Bellona Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Allen

(a) Residence No. 329 E. 21. St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, Married, Widowed, or ~~Divorced~~ (~~Write the word.~~) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Keefer

6-DATE OF BIRTH (month, day and year) 1851

7-AGE. 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). retired
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS:
10-NAME OF FATHER, Wm. M. Allen
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna
12-MAIDEN NAME OF MOTHER, Mary M. Miller
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-
(Informant) Mrs. Rose E. Neal
(Address) 329 E. 21. St.

15-
DEC 1 - 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 28. 24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1914 to Nov 28 1924
that I last saw h~~is~~ alive on Nov. 28. 1924
and that death occurred, on the date stated above, at 10.45 a.m.
The CAUSE OF DEATH* was as follows:
Paralysis Agitans

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robt Kane M. D.

11-30, 1924 (Address) 5900 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Cemetery — DATE OF BURIAL. Dec 1., 1924

20-UNDERTAKER. Geo. Crutchfield — ADDRESS 1201 N. Bayview St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92460

CERTIFICATE OF DEATH.

D 92460

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1812 Hanneman St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Vacek

(a) Residence No. 1812 Hanneman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 1879

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Pioneer Salesman

(b) General nature of industry, business, or establishment in which employed (or employer). Street

(c) Name of employer. 066

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Paul Vacek

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

11- (Informant). Mary Johnson

(Address) 1029 Pulaski Co

DEC 1 - 1924

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 28/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 19 24 to Nov 28 19 24

that I last saw h[illegible] alive on Nov 28 19 24

and that death occurred, on the date stated above, at 1 PM.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed 11-29-24 Dr. Frederick Bonkowski, M.D.

19 (Address) 260 N Mad St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Dec 1 19 24

20-UNDERTAKER. Frank Evard Son — ADDRESS. 1906 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 92461

D 92461

CERTIFICATE OF DEATH.

REGISTERED NO. 25 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 Cedar Ave. ST. WARD)

2-FULL NAME Elmer Albert Franklin Romm. (Husband)

(a) RESIDENCE. NO. 224 Cedar Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) (Infant)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Elmer Romm

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Otto

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Elmer Romm
(Address) 224 Cedar ave.

15 DEC 1 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1924, to Nov. 10, 1924.

that I last saw h. alive on Nov. 10, 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

Nov 10, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Dec. 1 1924

20 UNDERTAKER George L. Schwartz ADDRESS 1101 Eutaw St.

This is a CONFIDENTIAL RECORD, and each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92462

CERTIFICATE OF DEATH.

179 D 92462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital WARD)

2-FULL NAME Mrs Norman W Carpenter

(a) RESIDENCE NO. 1317 Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~: Mary L. Carpenter

6 DATE OF BIRTH (month, day, and year) May 11, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Leyton Stove Co.

9 BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10 NAME OF FATHER: Rev Lucius D Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vermont

12 MAIDEN NAME OF MOTHER: Emma Worster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Illinois

14 Informant: Mrs Carpenter

(Address) 1317 Park Ave

15 DEC 1 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 19 24, to Nov 30 19 24,

that I last saw him alive on Nov. 30 19 24,

and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Austin Dearth, M. D.

11/30 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Dec 2 1924

20 UNDERTAKER: Henry H Jenkins & Son Co

ADDRESS: Eutaw & Fayette Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

Mary Flickinger

HEALTH DEPARTMENT—CITY OF BALTIMORE

92463

CERTIFICATE OF DEATH.

D 92463

1-PLACE OF DEATH Church Home & Infirmary

Registered No.

City of BALTIMORE: (No. ..... St., 17 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flickinger, Mrs. Mary

(a) Residence No. 2603 Huntington Avenue St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Harry P. Flickinger

6-DATE OF BIRTH (month, day and year) Sept 31 1871

7-AGE. 53 yrs. 2 mos. 26 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Carroll Co, Md

PARENTS

10-NAME OF FATHER. Ezra D. Stuller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll Co. Md

12-MAIDEN NAME OF MOTHER. Hester M Fleagle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carroll Co Md

14-

(Informant) Hester Dorsey

(Address) 2603 Huntington Ave

15-

DEC 1 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 29–24

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 to 24 to Nov 29 to 24

that I last saw h[illegible] alive on Nov 29 to 24

and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage & hemiplegia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic nephritis ?

(Duration) ..... ? yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 26, 1924

Was there an autopsy? Yes Clinical symptoms & autopsy

What test confirmed diagnosis?

(Signed) Henry U. S. Wilson M. D. M D

, 19 (Address) Church Home & Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem Dec 2 19 24

20-UNDERTAKER. H. S Marshall ADDRESS 3539 Falls Road

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 92464

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 D 92464

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 S. Stricker St., 14 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan N Linthicum

(a) Residence No. 109 S Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: Single (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year): Dec 23 1853

7-AGE. 70 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Dorchester Co Md

PARENTS

10-NAME OF FATHER: Francis Linthicum

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Dorchester Co Md

12-MAIDEN NAME OF MOTHER: Sarah A Harrington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Dorchester Co Md

14- (Informant) Mrs Laura J Wheeler

(Address) 506 N Fulton Ave

15- Filed DEC 1 - 1924 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924 to Nov 27 1924

that I last saw h.r alive on Nov 25 1924

and that death occurred, on the date stated above, at 11 20 p m.

The CAUSE OF DEATH* was as follows:

Suppression of Urine

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. Edw Smyth M. D.

11/29 1924 (Address) 910 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Dec 1 1924
20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 92465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D 92465

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1002 W. Franklin St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Florence E. Imhoff

(a) Residence No. 1002 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Imhoff

6-DATE OF BIRTH (month, day and year) May 27 1857

7-AGE. 67 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer). 021

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William Barnet

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Eastern Shore

12-MAIDEN NAME OF MOTHER. Rossell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Eastern Shore Md

14- (Informant) Mr. Henry Imhoff

(Address) 1002 W. Franklin St.

15- Filed DEC 1 - 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 30/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1924 to Nov 30th 1924

that I last saw her alive on Nov. 29 1924

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Do not know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carrick, M. D.

, 19 (Address) 412 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Dec 2 19.24

DATE OF BURIAL,

20-UNDERTAKER. Mrs. Mrs. John H. Tesseff & Son

ADDRESS 801 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1794 D 92466

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 N Luzerne ST. ave 6 WARD)

2-FULL NAME Matilda Creamer

(a) RESIDENCE NO. 235 N Luzerne ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Say 40 yrs. mos. ds. How long in U. S., if of foreign birth? Say 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Creamer

6 DATE OF BIRTH (month, day, and year) Feb 14 1843

7 AGE 81 Years	Months 9	Days 15	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant George F. Reinmann
(Address) 235 N Luzerne ave

15 Filed DEC 1 - 1924 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to Nov 29, 1924, that I last saw her alive on Nov 28, 1924, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease and arteriosclerosis

over 2 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

over 2 yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Hyaline casts & urine

(Signed) Geo. T. Kemp, M. D.

Nov 30, 1924 (Address) St James Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dunety Cemetery	Dec 1 1924
20 UNDERTAKER	ADDRESS
Geo C Miller & Son	2334 Jeffries

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

D 92467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92467

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 235 N. Rose St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Napoleon Holland

(a) Residence No. 235 N. Rose St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~. (~~Write Single, Married~~ or Widowed.) Widower

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or ~~WIFE of~~) Emma V Holland

6-DATE OF BIRTH (month, day and year) Nov 28 1852

7-AGE. 72 yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stable Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Lanvin Lumber Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, John Holland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Cassandra Holland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Minnie Holland

(Address) 235 N Rose

15-

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

DEC 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 29-1924

17- I HEREBY CERTIFY, That I attended deceased from June 4 19 24 to Nov 29 19 24

that I last saw h.. alive on Nov 28 19 24

and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Floor of Urethra

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exanition + Exhaustion

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1924

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray + Operation

(Signed) Edward L Cook M. D

11/29 1924 (Address) 413 N Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem — DATE OF BURIAL, Dec 1st 19 24

20-UNDERTAKER Jas C. Fuller & Son — ADDRESS 2334 Jefferson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 19 129

City of BALTIMORE: (No. 216 N. Carey Street St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almira Bowen Crogan

(a) Residence No. 216 N. Carey Street St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. John Manning Crogan

6-DATE OF BIRTH (month, day and year) Sept. 27, 1846

7-AGE.	If LESS than 1 day,
78 yrs. 2 mos. 2 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired School

(c) Name of employer: Teacher

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Thomas Nicholson

11-BIRTHPLACE OF FATHER (city or town) Kent County
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eleanor D. Jean

13-BIRTHPLACE OF MOTHER (city or town) Baltimore County
(State or Country), Maryland

14- (Informant) Miss Margaret L. Crogan
(Address) 216 N. Carey Street

15- Filed DEC 1 - 1924 ROBERT R. KRANTZ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924, to Nov 29, 1924,

that I last saw h.w alive on Nov. 28, 1924,

and that death occurred, on the date stated above, at 8.55 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Brennan Stovall, M. D.

11-29 1924 (Address) 626 N. Gilmor Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park Cem	Dec 1st, 1924
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 W. Pratt St.

Burial Permit Issued

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92469

CERTIFICATE OF DEATH.

11-002

D 92469

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1145 Scott ST. 21 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa E. Carter (Rosa Elton Carter

(a) RESIDENCE. NO. 1145 Scott St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ArthurLee Carter

6 DATE OF BIRTH (month, day, and year) Mar. 25th, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Forewoman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Henry Jones (Address) 1145 Scott Street

15 Filed DEC 1 - 1924 WORTH R. KRAUTER, Registrar. Health Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1924, to Nov 2, 1924, that I last saw h.. alive on Nov 2, 1924, and that death occurred, on the date stated above, at 7.20 A m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

Nov 29 1924 (Address) 517 Loudon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 1 24
20 UNDERTAKER	ADDRESS
J & B Cook	1003 W Balto

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S&S—21-0227—M&T—1500 Bks.

D 92470

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92470

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ERNEST MELVIN JARMIN

(a) RESIDENCE No. Berlin - Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 weeks, 1 day mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Pennsylvania R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Berlin

(State or country) Maryland

PARENTS

10 NAME OF FATHER Howard B. Jarman

11 BIRTHPLACE OF FATHER (city or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Laura Melvin

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Mr. Howard B. Jarmin

(Address) 1213 N. Calvert Street

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-24

17

I HEREBY CERTIFY, That I attended deceased from 11/8/24, 19 ..., to 11/30/24, 19 .

that I last saw h/ Malive on 11/30/24 19 .

and that death occurred, on the date stated above, at 11.57 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) ..... yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus instantaneous

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) ..... M. D.

12-1, 19 24 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Berlin Md

DATE OF BURIAL Dec 1 1924

UNDERTAKER Jos B Cook

ADDRESS 1003 N Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 92471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 92471

1-PLACE OF DEATH outpatient Registered No.

City of BALTIMORE: (No. 30 Annapolis Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ivan Jerome Emmerich

(a) Residence No. 30 Annapolis Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 8 1923

7-AGE. 1 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore md

PARENTS.

10-NAME OF FATHER. Ivan Emmerich

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore md

12-MAIDEN NAME OF MOTHER. Florence Mihm

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore md

14- (Informant). Ivan Emmerich

(Address) 30 Annapolis Ave

15- Filed DEC 1 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 23, 1924, to Nov 30, 1924

that I last saw him alive on Nov 30 1924

and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) d.t. Imon

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? mental examination

(Signed) W. E. Krupp M. D.

11/30/24, 19 (Address) 1001 W Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Bud Cem — DATE OF BURIAL. Dec 2 1924

20-UNDERTAKER. Jos Loesers Son — ADDRESS 217 S Para

N. B.—WHITE PAPER REGISTERS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92472

CERTIFICATE OF DEATH.

90 D 92472

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 E Hoffman ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Stevens.

(a) RESIDENCE. No. 1917 E Hoffman ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Steven

6 DATE OF BIRTH (month, day, and year) Nov 4. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie E Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant W. W. Pierce (Address) 1730 Harford Ave.

15 Filed DEC 1 - 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 19 24 to Nov 30, 19 24

that I last saw her alive on Nov 30, 19 24

and that death occurred, on the date stated above, at 12 45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

of Heart.

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sandison, M. D.

, 19 (Address) 1714 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 12/2 19 24

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92473

CERTIFICATE OF DEATH.

1001

D 92473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General Hospital.

CITY OF BALTIMORE: (No. Rayner ave & Dukeland ST., 21 WARD)

2-FULL NAME Mr Jerome Meyers Jr

(a) RESIDENCE NO. 10 W woodland ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11 1905

7 AGE	19 Years	2 Months	15 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Window Dresser.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mr Jerome Meyers, Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Miss Edna Heck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Jerome Meyers, Sr.

(Address) 10 W woodland ave - Balto. Md

DEC 1 - 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/21, 1924, to 11/26, 1924,

that I last saw him alive on 11/26, 1924,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Intestinal Perforation sec Typhoid Peritonitis

11 hrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no yes Date of 11/26/24

Was there an autopsy?

What test confirmed diagnosis? Operation - Widal

(Signed) Clement R Monod, M. D.

, 19 (Address) West Balto General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Dec 1 1924

20 UNDERTAKER: Wm J Pickuer Sons ADDRESS: North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert R. Kramer
Asst. Public Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92474

CERTIFICATE OF DEATH.

31 D 92474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 247 Guilford St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie Virginia Crouse

(a) RESIDENCE NO. 247 Guilford Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul N. Crouse

6 DATE OF BIRTH (month, day, and year): Jan 5 1873

7 AGE — Years: 51 — Months: 10 — Days: 24 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Balto. C. Md

PARENTS

10 NAME OF FATHER: W.m W Shroyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto C. Md

12 MAIDEN NAME OF MOTHER: Matilda C. Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Paul N Crouse 247 Guilford Ave.

15 Filed ..... 19 ..... Registrar

DEC 1 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1 1924 to Nov 29 1924.

That I last saw her alive on Nov 26 1924

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

from history (duration) 4m yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. H. Grayhom M. D.

Dec 1 1924 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: Dec 2 1924

20 UNDERTAKER: Wm J Pickner & Sons — ADDRESS: Norbeck

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92475

CERTIFICATE OF DEATH.

100-00 D 92475

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3707 Springdale Ave (St.) 5 (WARD)

2-FULL NAME Louise Otto Pomplety

(a) RESIDENCE No. 3707 Springdale Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 1 mo. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (a) HUSBAND of (or) (b) WIFE of: August Pomplety

6 DATE OF BIRTH (month, day, and year): Oct 23 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Fredk Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Emma L. Stillman 3 E. 6th St. Plainfield N.J.

15 Filed 19 ROBERT R. KRAUSER, Registrar

DEC 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20. 1924. to Nov. 30. 1924.

that I last saw h[illegible] alive on Nov. 29. 1924.

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robt C. Blake M. D.

19 (Address) 1417 W Fa Bayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery | DATE OF BURIAL: Dec 2 1924

20 UNDERTAKER: Wm J Pickney & Sons | ADDRESS: North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92476

CERTIFICATE OF DEATH.

D 92476

1-PLACE OF DEATH

City of BALTIMORE: (No. 1005 Roland Ave St., 27 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice McBlair Rinehart

(a) Residence No. 1005 Roland Ave St., 27 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. 26 ds. 2 How long in U. S., if of foreign birth? 75 yrs. 6 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Evan T. Rinehart

6-DATE OF BIRTH (month, day and year) May-3-1849

7-AGE 75 yrs. 6 mos. 26 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, James Warden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Alice McB. Roney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Maryland

14- (Informant) Mrs. T. Warden Rinehart (Son)
(Address) 2922 N. Calvert St.

15- Filed DEC 1 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/29/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 1924 to Nov 28 1924

that I last saw her alive on Nov 28 1924

and that death occurred, on the date stated above, at 6-9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. 20 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

11/29, 1924 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemy | DATE OF BURIAL, Dec 1 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) | ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of Occupation and Birthplace required. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92477

CERTIFICATE OF DEATH.

X 101-001

D 92477

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 632 Laurens ST., (14 WARD)

2-FULL NAME Sanford Reynolds

(a) RESIDENCE No. 632 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta N Reynolds

6 DATE OF BIRTH (month, day, and year) March 8 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 640

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Patsy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Emma Reynolds

(Address) 632 Laurens

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 26th, 1924, to Dec 14, 1924, that I last saw h alive on Dec 14, 1924, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) as E. D. Bell, M. D.

, 19 (Address) 1124 Belnord Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Pa Mt Auburn Loan

DATE OF BURIAL Dec 8-1924

20 UNDERTAKER David Carlson

ADDRESS 846 Cars

SEP 1 - 1924 FOREST B. KRAUTER, [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92478

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1914 Herbert St St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Raymond Bloom

(a) Residence No. 1914 Herbert St St., Balt Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? 5 yrs. 2 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of -

6-DATE OF BIRTH (month, day and year) 9/13/1919

7-AGE. 5 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, Elmo Bloom

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Lizzie Warfield

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Elmo Bloom

(Address) 1914 Herbert St Balto

15-

Filed ..... 192..

DEC 1 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11/29/24

17- I HEREBY CERTIFY, That I attended deceased from 11-28- 1924 to 11/29 1924

that I last saw him alive on 11/25 1924

and that death occurred, on the date stated above, at 2.10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds

CONTRIBUTORY (Secondary) Infantile Paralysis

(Duration) ..... yrs. 6 mos. ..... ds

18-Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Not Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. F. Bungard M. D.

, 19 (Address) 1914 Herbert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem — DATE OF BURIAL. 12-1-24

20-UNDERTAKER. Dunn Earley — ADDRESS 916 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A

Spec.—1-10-21—M&T—1500 Bks.

D 92479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92479

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Randolph

(a) RESIDENCE NO. 1111 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 940

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George Randolph

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Municipal Hospital Records

(Address)

15 Filed DEC 1 - 1924 19 Burial Permit Issued

ROBERT R. KRAMER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-22, 1924, to 11-29, 1924,

that I last saw h~~e~~alive on 11-29, 1924

and that death occurred, on the date stated above, at 8 00 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos. (History) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Surg & Autopsy

(Signed) Claude S. Dorsey M. D.

11-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-2-24
20 UNDERTAKER	ADDRESS 986
Dent Easton	Pace

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-24—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92480

D 92480

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 S. Fremont Ave. ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Gibbs.(C).

(a) RESIDENCE NO. 1013 S. Fremont Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Widower.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Bessie Gibbs.(C).

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Cecil Reddech.(C).
(Address) 915 Leadenhall Street.

15 Filed DEC 1 - 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Stabwound in the Heart. Homicide.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Otto M. Steinhardt (Coroner.) M. D.

Dec. 1st, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn — DATE OF BURIAL: Dec 1 1924

20 UNDERTAKER: R L Parham — ADDRESS: 902 Leadenhall St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec—12423-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92481

CERTIFICATE OF DEATH.

12 D 92481

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2902 Orleans St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Shangenberger

(a) Residence No. 2902 Orleans St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Minnie J. Shangenberger

6-DATE OF BIRTH (month, day and year) Oct 1/65

7-AGE. 59 yrs. 1 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Police 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Geo. F. Shangenberger

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Carolnie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Minnie J. Shangenberger

(Address) 2902 Orleans St

15- DEC 1 - 1924 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 28/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 19 24 to Nov 28 19 24

that I last saw him alive on Nov 28 19 24

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

Hypertension — Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac

Arteriosclerosis (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Leslie Swindler M. D.

1924 (Address) 1016 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and, (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood

DATE OF BURIAL. Dec. 2, 1924

20-UNDERTAKER. Philip Henry

ADDRESS 2016 Orleans St

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92482

Registered No. 17

1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 N. Milton Ave. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen B. Finck

(a) Residence No. 1135 N. Milton Ave. Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced (HUSBAND of) (or) WIFE of J. Henry Finck

6-DATE OF BIRTH (month, day and year) Nov. 15, 1846

7-AGE. 78 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home Worker

(b) General nature of industry, business, or establishment in which employed (or employer). at Home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Stork

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Daughter Mrs. Edward J. Heuer

(Address) 1135 N. Milton Ave

15-

Filed DEC 1 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924 to Nov 28 1924

that I last saw her alive on Nov 28 1924

and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T Avery M. D.

, 19 (Address) 1603 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore County

DATE OF BURIAL. Dec 1. 1924

20-UNDERTAKER. Edmund W. Conklin

ADDRESS 924 E Eager st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122 D 92483

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital, 9 WARD)

2-FULL NAME Patrick J. Diggins

(a) RESIDENCE NO. 719 Ensworth St., ~~Scott~~ Gilbert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE: 44 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 044

(b) General nature of industry, business, or establishment in which employed (or employer) Bar Tender

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ger

PARENTS

10 NAME OF FATHER Dorfmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorfmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

DEC 1 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29/24

17 I HEREBY CERTIFY, That I attended deceased from 11/1/24, 19, to 11/29/24, 19, that I last saw h alive on 11/29/24, 19, and that death occurred, on the date stated above, at 12.[illegible] m.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Holley, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ho Greenmount Dec 2 1924

DATE OF BURIAL

20 UNDERTAKER: J G Moran

ADDRESS 3 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dunphey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92484

CERTIFICATE OF DEATH.

113

D 92484

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 S Chapel ST. 7 WARD)

2-FULL NAME Thomas C Dunphey

(a) RESIDENCE. No. 240 S Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lester Dunphy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Helen Hogan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Lester Dunphy
(Address) 240 S Chapel St

15 Filed DEC 1 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Nov 29, 1924, that I last saw h— alive on Nov 29, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Ryanek M. D.

(Address) 801 Eastwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec 1st 1924
20 UNDERTAKER J. G. Moran	ADDRESS 208 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92485

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hosp. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard A. Dixon

(a) Residence No. 1902 Homewood St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Laura E. Dixon

6-DATE OF BIRTH (month, day and year): Sept 10, 1874

7-AGE: 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: U.S. Gauger 186

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto, Md

PARENTS:

10-NAME OF FATHER: Thos Dixon

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Margaret Weaver

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Frederick Md

14-Informant: Laura E. Dixon

(Address): 1902 Homewood Ave

15-

DEC 1 - 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 19 24 to Nov. 30 19 24

that I last saw him alive on Nov. 30 19 24

and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:

1) Intestinal Obstruction

2) Toxemia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Myocarditis

(Duration) yrs. X mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 29/24

Was there an autopsy? no

What lest confirmed diagnosis? Phys. & Clin. Death

(Signed) Geo Bryant M. D

19 (Address) St Josephs Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Dec 2, 1924
20-UNDERTAKER,	ADDRESS
Wm Cook	804 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 92486

Cert. 1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 D 92486

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2218 Booth ST., 20 WARD)

2-FULL NAME John J. Baerschmidt

(a) RESIDENCE No. 2218 Booth ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 18 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None - Blind
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. A. Baerschmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. A. Baerschmidt
(Address) 2209 W. Lexington St

15 Filed DEC 1 - 1924, 192... Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Asphyxiation by Illuminating Gas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. J. Horton, M. D.
(Coroner.)

Nov 30 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2218 Booth

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 1 1924

20 UNDERTAKER W. W. Cook — ADDRESS 502 E. Fayette

...should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92487

CERTIFICATE OF DEATH.

X145 001

D 92487

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

2-FULL NAME Alice Easton

(a) RESIDENCE No. West Friendship - Howard Co. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Archie Easton

6 DATE OF BIRTH (month, day, and year): Aug. 24. 1901

7 AGE: Years 23 Months #3 Days 5 — If LESS than 1 day, ...hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Trail

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Archie Easton

(Address): West Friendship - Md.

15 DEC 1 - 1924 ROBERT R. KRAMER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1924. to Nov 29, 1924.

that I last saw her alive on Nov. 29, 1924.

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Caesarian section

on 11-25-24 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-25-24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jennings Chapel

DATE OF BURIAL: Dec 2 1924

UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

Spec.—1-10-21—M&T—1500 Blks.

Eugene Bruinn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92488

D 92488

CERTIFICATE OF DEATH. X 11

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hosp ST., 4 WARD)

2-FULL NAME Eugene Bruinn

(a) RESIDENCE NO. Ellicott City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Bruinn

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Bruinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Rondel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hof Records (Address)

15 Filed DEC 1 - 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1924, to Nov 1, 1924, that I last saw him alive on Nov 1, 1924, and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum Ruptured Appendix

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov. 28, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Buchanan, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Dec. 3 19 24

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 17116

D 92489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161,001

D 92489

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 20 WARD)

2-FULL NAME William H. Lewis

(a) RESIDENCE NO. 1946 W Mulberry St., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. white mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER William H. Lewis

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) England

12 MAIDEN NAME OF MOTHER Mary Parkinson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) England

14

Informant .....

(Address) .....

15

DEC 1 - 1924

Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 5, 1924, to Nov 25, 1924, that I last saw him alive on Nov 25, 1924, and that death occurred, on the date stated above, at 8 45/60 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park — DATE OF BURIAL: Nov 28 1924

UNDERTAKER: Harry H. Weitzel — ADDRESS: 1531 W Lan...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92490

CERTIFICATE OF DEATH.

D 92490

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1164 Low St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Warfield

(a) Residence No. 1164 Low St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M. 4-COLOR OR RACE, C. 5-~~Single, Married, Widowed, or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) ?

7-AGE, 48 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Storekeeper

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lexington Ky.

PARENTS.

10-NAME OF FATHER, ? Warfield

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ky.

12-MAIDEN NAME OF MOTHER, Can't state.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ky.

14- (Informant) Elnora Gordon

(Address) 1114 Arlington st

15- DEC 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 29/24

I HEREBY CERTIFY, That I attended deceased from Nov 25 1924 to Nov 29 1924

that I last saw him alive on Nov 28 1924

and that death occurred, on the date stated above, at 5 20am m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. 1 da.

18-Where was disease contracted if not at place of death? 1164 Low St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

11/29/24 (Address) 1207 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem't — DATE OF BURIAL, 12/1/24 1924

20-UNDERTAKER, Byron Wright — ADDRESS 1218 McElderry st

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92491

CERTIFICATE OF DEATH.

D 92491

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 17 WARD)

2-FULL NAME Lottie Simms

(a) RESIDENCE No. 946 Druid Hill Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? . yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 870

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer Meath.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Caspar Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward Carey

(Address) 1912 Lombard St Balto Md

15 Filed DEC 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1924, to Nov. 29, 1924, that I last saw her alive on Nov 29, 1924, and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

(1) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of — — —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L Anderson M. D.

11-29, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pandora Virginia

DATE OF BURIAL 12/1 1924

20 UNDERTAKER Samuel D Sweeney

ADDRESS 778 N Bidale St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92492

CERTIFICATE OF DEATH.

B 92492

REGISTERED NO. 1615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 N. Bond ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Leo B. & Barrie M. Culhane

(a) RESIDENCE. No. 1118 N. Bond ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 30-1924

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 15 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1118 N. Bond St. Baltimore, Md.

PARENTS

10 NAME OF FATHER Leo B. Culhane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Milan Mich.

12 MAIDEN NAME OF MOTHER Barrie M. Bartell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Govans Md.

14 Informant Leo B. Culhane (Address) 1118 N. Bond st

15 Filed DEC 1 - 1924, 19... ROBERT R. KRAUTER Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30-1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30 -, 1924 to Nov. 30 -, 1924 that I last saw h alive on Nov. 30 -, 1924 and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Miscarriage at 8 mos. gestation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

11/30/1924 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Mary's, Hampden	Dec 4 1924
20 UNDERTAKER Zerkler & Zerkler	ADDRESS 734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 V D 92493

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. Fremont ST., 17 V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zelma Ricks

(a) RESIDENCE NO. 215 S. Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) nov. 28. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... cin

(b) General nature of industry, business, or establishment in which employed (or employer) ... 000

(c) Name of employer

9 BIRTHPLACE (city or town) ... Md. D
(State or country)

PARENTS

10 NAME OF FATHER calip ricks

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER robbie white

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant calip ricks
(Address) 215 S. fremont ave

15 Filed DEC 1 - 1924 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-1924

17

I HEREBY CERTIFY, That I attended deceased from 11-28-, 1924, to 11-30-, 1924, that I last saw h~~er~~ alive on 11-30-, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Contracted pelvis

(of mother)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Dr. T. Carpin, M. D.

12-1-1924 (Address) 611-N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bury cemetery	dec 1 1924
20 UNDERTAKER Edward Bryan	ADDRESS 631 orleans

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92494

CERTIFICATE OF DEATH.

111-001

D 92494

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2125 Eutaw St. W.H. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Bowen

(a) RESIDENCE NO. 2125 Eutaw ST. W.H. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Bowen

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 75 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Ayers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lillian Potter

(Address)

15 Filed DEC 1 - 1924 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1924, to Nov 24, 1924, that I last saw her alive on Nov 24, 1924, and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows: Ulcer of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

(Address) 2359 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W.L. Woburn — DATE OF BURIAL: Dec 2, 1924

20 UNDERTAKER: L. A. Brooks — ADDRESS: 1465 Gough

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92495

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 300 r Auchentorly Terrace St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Barbara Krenzer

(a) Residence No. 300 r Auchentorly Terrace St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Christopher Krenzer

6-DATE OF BIRTH (month, day and year) Sept 29-1843

7-AGE. 81 yrs. 1 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Andrew Finkelmann

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Angela

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant)..... Joseph C. Lantner

(Address)..... 30 l or Auchentorly Ter.

15- Filed DEC 7 1924 Robert P. Harrison, 192..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 28-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10 ....., 1921 to Nov. 28 ....., 1924

that I last saw her alive on Nov. 28 ....., 1924

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Brights disease, diabetes,

Organic disease of heart

(Duration) 3 yrs. 2 mos. 28 ds.

CONTRIBUTORY (Secondary) Heart & Paralysis

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Albumen, Sugar Test

(Signed) J. Howe Hollins, M. D.

, 19 (Address) 1809 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral Cem	Dec 7 1924
20-UNDERTAKER, Tully & Zeiler	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92496 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92496

CERTIFICATE OF DEATH.

26 10

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 701 S. Sixth St. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edward Kratfel

(a) Residence No. 701 S. Sixth St. St., 26 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 28-1923

7-AGE. 1 yrs. 7 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Stephen Kratfel.

11-BIRTHPLACE OF FATHER (city or town)..... Austria
(State or Country),

12-MAIDEN NAME OF MOTHER Anna Tancibok

13-BIRTHPLACE OF MOTHER (city or town).... Austria
(State or Country),

14- (Informant) Anna Kratfel

(Address) 701 S. Sixth St.

15- Filed DEC 1 1924, 192.... Robert F. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 1-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 29, 19 24 to Dec 1, 19 24

that I last saw h.. alive on Dec 1, 19....,

and that death occurred, on the date stated above, at 5.40 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria Laryngeal

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ... yrs. ... mos. 1 ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W L Burke M. D.

, 19 (Address) 3047 Hudson Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St. Stanislaus	Dec. 3rd 1924
20-UNDERTAKER.	**ADDRESS**
Lilly & Zeiler	403 S. Wolfe St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92497

D 92497

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 7V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barney Callahan

(a) RESIDENCE NO. Conway & Shop ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widower

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER Thos. Callahan

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Julia Hodson

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 DEC 1 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1924, to Nov. 26, 1924, that I last saw h[illegible] alive on Nov 26, 1924 and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Lesion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis - Chronic Gen. Adh. (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) A. W. Buchner, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER [illegible]

ADDRESS [illegible]

DEC 1 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

DEC 1 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92498

D 92498

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mervins Benton

(a) RESIDENCE NO. Rock Hall, Kent Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hall, Kent Co.
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) JOHNS

15 Filed DEC 1 1924, 19 Robert P. Harrison, Registrar
1996

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1924, to Nov. 24, 1924,
that I last saw him alive on Nov. 24, 1924,
and that death occurred, on the date stated above, at 3.30 P m.
The CAUSE OF DEATH* was as follows:
(1) Broncho-pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senility (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Anderson, M. D.
, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL DEC 1-1924

20 UNDERTAKER Commissioner Health, — ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92499

CERTIFICATE OF DEATH.

161-4 01 D 92499

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2-FULL NAME Baby Stewart

(a) RESIDENCE NO. White Ca. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-27-24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. 15 min.
		→	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Earl Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Eleanor Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Eleanor Stewart

(Address) 1149 2. Clarence St Phila. Pa

15 DEC 1 - 1924 Robert F. Harrison, Registrar

1995

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1924, to 11-27, 1924.

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Mowey, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
HOPE	
20 UNDERTAKER Commissioner Health, Per Wm. E. WOODALL	ADDRESS DEC 1 - 19

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M & T—1500 Blks.

D 92500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92500

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McConville

(a) RESIDENCE NO. 2012 W. Fayette st. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 180

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McConville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Craney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ..... 19 ..... Registrar

DEC 1 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1924, to Nov. 30, 1924, that I last saw him alive on Nov. 30, 1924, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) J. A. White, M. D.

12-1-1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

12/3 1924

20 UNDERTAKER — ADDRESS

Wm. Tobey Rose 3 Eutaw Pl.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92501 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92501

CERTIFICATE OF DEATH.

160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. High ST.: 3 WARD)

2-FULL NAME Bernard Weglein

(a) RESIDENCE. NO. 118 S. West St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. 2 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Aug 26-1924

7 AGE — Years: — Months: 3 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Michael Weglein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bathurst

12 MAIDEN NAME OF MOTHER: Anna Langan Dec

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Bernard J. Weglein
(Address): 118 S. High St

15 Filed ..... 19 ..... Registrar

DEC 1 - 1924

Robert T. Harrison
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1924 to Nov 30, 1924 that I last saw h alive on Nov 30, 1924 and that death occurred, on the date stated above, at 11.8 a. m.

The CAUSE OF DEATH* was as follows: Marasmus and General debility due to malnutrition

(duration) 3 hrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cemetery — DATE OF BURIAL: 12/2 1924

20 UNDERTAKER: Chas. P. Crouch Son — ADDRESS: 118 W Mt Royal Ave

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92502

D 92502

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No.) 1707 N. Broadway (Ward) 8

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Jos. H. Rusk

(a) Residence No. 1707 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9½ yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE: Margt. Rusk

6-DATE OF BIRTH (month, day and year): July 1855

7-AGE: 69 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Edwin Rusk

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Elizabeth Dolan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) Margt. Bosson

(Address) 1707 N. Broadway

15- Filed DEC 1 1924, 192 Registrar.

Robert P. Harrison, Chief Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 29/24

I HEREBY CERTIFY, That I attended deceased from Oct 15 1924, to Nov 29 1924,

that I last saw h— alive on Nov 26 (29) 1924,

and that death occurred, on the date stated above, at 1 1 m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Not held

What test confirmed diagnosis? Clinical

(Signed) James M Benton M. D.

Dec 1 1924 (Address) 1012 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec 2 1924

20-UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Fremont Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92503 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33[d] & Calvert ST 12 (WARD)

REGISTERED NO. 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine T Hellman

(a) RESIDENCE No. 333 East 22[d] St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: John T Hellman

6 DATE OF BIRTH (month, day, and year): Sept 30 1873

7 AGE: 51 Years 1 Months 2 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Piano Tuner

(b) General nature of industry, business, or establishment in which employed (or employer): piano

(c) Name of employer: 086

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Andreas Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhemina Eberle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Springer

(Address) 3921 Ridgewood Ave

15 DEC 1 1924 ...19... Robert L. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Nov 27, 1924, that I last saw him alive on Nov 27 at 10[a] m, 1924, and that death occurred, on the date stated above, at 10[a] 5 m.

The CAUSE OF DEATH* was as follows:

Obstruction to common bile duct.

6 mos (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cholangitis. stone.

2 mos (duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? yes Date of 11/21/24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A B Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Nov 29 1924

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 Broadway

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92504

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 712 Springhill Terrace St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Dr. Lot Ridgely Wilson

(a) Residence No. 712 Springhill Terrace St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Mercier Wilson

6-DATE OF BIRTH (month, day and year) June, 9th 1858

7-AGE: 66 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: John Webster Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Sara Jane Ridgely

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14- (Informant): Mrs. Mareese Wilson Burgan

(Address): 712 Springhill Terrace

15- Filed....., 192.... Robert F. Harrison, Registrar.

DEC 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 29th 1924

17- I HEREBY CERTIFY, That I attended deceased from October, 1923, to Nov 29, 1924, that I last saw h. alive on Nov 29, 1924, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia Jaundice

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of October 1924

Was there an autopsy?

What test confirmed diagnosis? Abdominal Incision

(Signed) C. Hunt Smith, M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. | DATE OF BURIAL, Dec 2, 1924

20-UNDERTAKER: Joseph B Cook | ADDRESS: 1003 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Linden Ave + Brooks Lane.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92505

CERTIFICATE OF DEATH.

90 D 92505

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Georgian Court Apt. ST., 13 WARD)

2-FULL NAME Wolf Kaufman

(a) RESIDENCE NO. Georgian Court Apt ST., C 3 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Rachel Kaufman.

6 DATE OF BIRTH (month, day, and year) Oct. 15th 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	1	15	

8 OCCUPATION OF DECEASED Ret.

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Binau. Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Bessie Kaufman

(Address) Georgian Court Apt.

15 DEC 1 - 1924 .19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1924.

17 I HEREBY CERTIFY, That I attended deceased from May, 1924. to Nov. 29, 1924.

that I last saw him alive on Nov. 29, 1924,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Myocardial insufficiency.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pulmonary embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) I B Sherman M. D.

11-30, 1924 (Address) 1012 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ohel Shalom Cem.	12/2/1924
20 UNDERTAKER	ADDRESS
Saml Sondheim	118-20 W. Mt. Royal Ave

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stella G. Smith ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92506

CERTIFICATE OF DEATH.

11-0 D 92506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Eutaw Place. ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella G. Smith

(a) RESIDENCE NO. 1910 Eutaw Place. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph L. Smith

6 DATE OF BIRTH (month, day, and year) Dec. 4th. 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charlestown, (State or country) W. Va.

PARENTS

10 NAME OF FATHER Joseph Goldsmith

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Hamburger

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mrs. Henry Goldsmith (Address) Thorsonian Apts

15 Filed DEC 1 - 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1st. 1924.

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1923, to Dec 1, 1924, that I last saw h e alive on Dec 1, 1924, and that death occurred, on the date stated above, at 11.35 A.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Streptococcus Septicaemia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) Emma F. Mayer, M. D.

12/1, 1924 (Address) The Esplanade.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	12/ /19 24

20 UNDERTAKER David Sondheim ADDRESS 118-20 W. Lexington St. Eutaw Pl.

Spec. 1-10-21 M&T 1500 Bks.

D 92507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 164 N. Gross St., WARD) 21

REGISTERED NO. 289

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence G. Meyers

(a) RESIDENCE No. 164 N. Gross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos.

(If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard T. Meyers

6 DATE OF BIRTH (month, day, and year): Aug 5 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Maurer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary Dorlan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Howard T. Meyers 2619 Kirby Lane

15 Filed DEC 1924, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 28 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to Nov. 28, 1924

that I last saw her alive on Nov 28, 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Both Lungs.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas N. Magruder M. D.

, 19 (Address) 14 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 2 1924
UNDERTAKER	ADDRESS
H B Stephenson	1854 N. Balto St

Burial Permit

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item, entry and erasure should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92508

CERTIFICATE OF DEATH.

D 92508

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Uppm Fremont Hosp. St. WARD)

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Cork

(a) RESIDENCE No. 2914 Guilford Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Cork.

6 DATE OF BIRTH (month, day, and year) Apr 23 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John G. Clerk

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Rosella Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Lena Cork
(Address) 2914 Guilford Av

15 Filed DEC 1 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Injuries due to accident
Accidental

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 1, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	12/2/1924
20 UNDERTAKER	ADDRESS
E. D. Fanning's Son - 1938 E. Lafayette Ave.	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92509

CERTIFICATE OF DEATH.

4 75-002

D 92509

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 781 Sarah ann St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Thomas Tollany

(a) Residence No..... 781 Sarah Ann St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE. 51 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer 0440

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER. Thomas Tollany

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER. Ann Tollany

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Baltimore Md.

14- (Informant) Sarah Tollany

(Address) 781 Sarah Ann St

15- DEC 2 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 30 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... Nov 24, 1924 to Nov 30 1924

that I last saw h.. alive on ..... Nov 24, 1924

and that death occurred, on the date stated above, at 11.5 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral

(Duration) mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Stenosis

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. Hoover, M. D.

Dec 1, 192 (Address) 712 S Paca

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
National Park	12-2-24
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92510

CERTIFICATE OF DEATH.

X 38 D 92510

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bailey

(a) RESIDENCE NO. 555 W. Lafayette ST., WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Louis Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Municipal Hospital

(Address)

15 Filed DEC 2 - 1924 VINCENT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-20, 1924 to 11-28, 1924

that I last saw him alive on 11-28, 1924

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis;

Aortic Insufficiency;

Myocardial Insufficiency

(duration) yrs. 6 mos. Unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Black, M. D.

11-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Linton N C	12-3-24
20 UNDERTAKER	ADDRESS
Daniel Easton	Linton N C

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92511

D 92511

CERTIFICATE OF DEATH.

32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

2-FULL NAME Mrs Minnie Brodsky

(a) RESIDENCE NO. 135 N. Exeter ST., / WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Aaron Brodsky

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 57 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Alter Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Nathan Brodsky

(Address): 1215 E. Fenton St.

15 Filed DEC 2 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-1 1924

17

I HEREBY CERTIFY, That I attended deceased from 9/ 11/ 24, 19, to 12/ 1/ 24, 19,

that I last saw h e alive on 12/ 1/ 24, 19

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

I. B. Meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) T. B. of spine with psoas abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? yes Date of Oct 20

Was there an autopsy? No.

What test confirmed diagnosis? Clinical signs

(Signed) Philip Jacobson, M. D.

, 19 (Address) Mt Sinai Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 12/2 1924

20 UNDERTAKER: Jack Lewis 1434

ADDRESS: E Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 92512

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 834 S. Eutaw St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Sachs

(a) Residence No. 834 S. Eutaw St., 27 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jerry Sachs

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Lasptery Snipes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Luella Sayla

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Jerry Sachs

(Address) 834 S. Eutaw

15-

Filed DEC 2 - 1924 19.. Robert R. Krauter, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-28-24

17- I HEREBY CERTIFY, That I attended deceased from 9/5 19 24 to 11/28 19 24

that I last saw h alive on 11/28 19 24

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchopneumonia

(Duration) 1/2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Klinefelter, M. D.

11/29/, 19 24 (Address) 1908 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn DATE OF BURIAL, Dec 2, 19 24

20-UNDERTAKER, John H. Toadvine ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92513

CERTIFICATE OF DEATH.

12 D 92513

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4115 Belvieu Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine M. Franklin

(a) RESIDENCE No. 4115 Belvieu Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced ~~HUSBAND of~~ (or) WIFE of E. Dorsey Franklin

6 DATE OF BIRTH (month, day, and year) May 6-1875

7 AGE — Years: 49 — Months: 6 — Days: nf

If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John R. Murray

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Jeanne Kenny

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant E. Dorsey Franklin

(Address) 4115 Belvieu Ave

15 Filed DEC 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922, to Nov. 30, 1924.

that I last saw her alive on Nov. 30, 1924.

and that death occurred, on the date stated above, at 8.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,

(duration) 2 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. C. Clark, M. D.

Dec 4 1924 (Address) Chas. Med Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 12/3 1924

20 UNDERTAKER: Wm. J. Jackson Sons

ADDRESS: No. Paca

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92514

CERTIFICATE OF DEATH.

12 3 D 92514

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Licklider

(a) RESIDENCE No. 1825 N. Montford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Licklider

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Asbury Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) a.a. County md

12 MAIDEN NAME OF MOTHER Emma Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) a.a. County md

14 Informant Harry Licklider

(Address) 1825 N montford ave

15 DEC 2 - 1924 ROGER N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-13- , 1924, to 11-30 , 1924.

that I last saw her alive on 11-30- , 1924.

and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tbc.

Cholelythiasis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) a Pyelo Nephritis.

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? 1825 N. Montford Ave.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Winston Dj M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PARKWOOD CEMETRY	DEC 3 1924
20 UNDERTAKER ROBERT BROOKS & SON	ADDRESS CALHOUN HOLLINS Sts

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92515

CERTIFICATE OF DEATH.

16 I-001

D 92515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2721 Harlem Ave ST., WARD)

2-FULL NAME Infant Cooney (not named)

(a) RESIDENCE NO. 2721 Harlem ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1, 1924.

7 AGE — Years — Months — Days — If LESS than 1 day, 12 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER 2721 Harlem Eugene Cooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillie A Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Eugene F Cooney

(Address) 2721 Harlem

15 Filed ... 19 ROBERT R. KRAUTER, Registrar

DEC 2 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/24 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 ... 1924 ... to Dec 1/24 ... 19 ...

that I last saw him alive on Dec 1/24 ... 19 ...

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth - about 7½ or 8 mo.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter Little, M. D.

Dec/24 19 (Address) 2220 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec 2 1924

20 UNDERTAKER: Geo. W. Little

ADDRESS 2708 Edmondson Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92516

CERTIFICATE OF DEATH.

100-001 D 92516

1-PLACE OF DEATH West Baltimore Gen'l Hospital

CITY OF BALTIMORE: (No. Regnor ave & Dukeland ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Henry Morden.

(a) RESIDENCE NO. 2545 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Amelia L. Morden

6 DATE OF BIRTH (month, day, and year) July 15, 1883

7 AGE	41 Years	5 Months	15 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Foreman Factory. 014

(b) General nature of industry, business, or establishment in which employed (or employer) Cabinet Makers.

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Henry Morden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Mauberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington DC

14 Informant (Address) Amelia Morden 2645 McHenry St

15 Filed DEC 2 1924 Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/29, 1924, to 12/1, 1924, that I last saw him alive on 12/1, 1924, and that death occurred, on the date stated above, at 12.00 P m.

The CAUSE OF DEATH* was as follows:

Bi-lateral Broncho-pneumonia.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Failure.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Clement A Monval, M. D.

, 19 (Address) Regnor ave & Dukeland st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL DEC 3 24

20 UNDERTAKER Henry H. Weitzel — ADDRESS 153 No. Londale

Cor.—1-12-23—M&T—100 Bks.

Wm A Haynes

D 92517

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001

D 92517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 W Lombard ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. A. Haynes

(a) RESIDENCE No 704 W Lombard ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
		5-		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Clarence Haynes.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Ella Stoker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Clarence Haynes'
(Address) 704 W Lombard St

15 Filed DEC 2 - 1924 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 5 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Case

(duration) yrs. mos. ds.

(Signed) W K Forman, M. D.
(Coroner.)

12. 2, 1924 (Address) 1127 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: 12/2/24 192

20 UNDERTAKER: Harry Wilke ADDRESS: 1531 W Lombard St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92518

CERTIFICATE OF DEATH. X 74 D 92518

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Christian ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy J. Brewer

(a) RESIDENCE NO. 2205 Christian ST., WARD Tennessee

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William King

6 DATE OF BIRTH (month, day, and year) Nov. 2 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81	-	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Daniel Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Lizzie Hubard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Ernest J. Brewer

(Address) 1208 Christian St

15 Filed DEC 2 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1924

17 I HEREBY CERTIFY, That I attended deceased from 7.2.24, 19 , to 11.28.24, 19 , that I last saw her alive on 11.27.24 19 , and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? chemical - Microscopic

(Signed) Philip B. Towles, M. D.

Dec 1, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Dec 2 1924
20 UNDERTAKER Chas L. Strouse	ADDRESS 1007 E Fort Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92519

CERTIFICATE OF DEATH.

D 92519

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 E 33rd St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula C. Hardesty

(a) Residence No. 307 E 33rd St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: William E. Hardesty

6-DATE OF BIRTH (month, day and year): July 23 1879

7-AGE. 45 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Edw Edmondson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Laura V. Spear

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Wm E. Hardesty

(Address): 307 E 33 St

15- DEC 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 30/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 4, 19 20, to Nov 30, 19 24, that I last saw h[illegible] alive on Nov 30, 19 24, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Encephalitis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Aug 10/24

Was there an autopsy? no

What test confirmed diagnosis? symptoms

12/1/24 19 (Signed) Alma B Lyman M. D

(Address) 718 N Fallsway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Dec 2 19 24

20-UNDERTAKER: E. A. Wedefeld

ADDRESS: 501 E 22

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S [illegible] in plain terms, so that it may be properly classified. instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92520

CERTIFICATE OF DEATH.

D 92520

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 W. North Avenue WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Philipp Berger, Jr.

(a) RESIDENCE. No. 809 W. North Avenue WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 29th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Philipp Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Beatrice M. Perrin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winston Salem N. C.

14 Informant John Philipp Berger Jr. (Address) 809 W. North Ave

15 Filed DEC 2 - 1924 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from November 22nd, 1924, to Dec 1st, 1924, that I last saw him alive on Dec 1st, 1924, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchopneumonia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan, M. D.

12/1, 1924 (Address) 1701 A Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem Cathedral	Dec 2 1924
UNDERTAKER E. A. Wiedefeld Jr	ADDRESS 501 E Cr

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state age should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92521

CERTIFICATE OF DEATH.

44 D 92521

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 956 W. Franklin St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ella V. Mead

(a) Residence No. 95 W Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward P. Mead

6-DATE OF BIRTH (month, day and year) 3/28/72

7-AGE,	If LESS than 1 day.
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hsw.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Henry Unkelbach

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Edward P. Mead

(Address) 956 W. Franklin St

15- DEC 2 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/1/24

17- I HEREBY CERTIFY, That I attended deceased from 11/6/24, 19....., to 12/1/24, 19.....

that I last saw h.. alive on 11/30/24, 19.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Dr. Martin M. Gwinn

What test confirmed diagnosis?

(Signed) Edward J. Levy, M. D.

12/1, 19 (Address) 7124 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Peters	December 3 1924
20-UNDERTAKER, George J Smith	ADDRESS 153 Hollins St

N. B.—WRITE PLAINLY, WITH INK. All items should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 28 WARD)

2-FULL NAME W. A. Bratley Gaither

(a) RESIDENCE NO. 3808 Montgomery AVE ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 18, 1863

7 AGE — Years: 61 — Months: 8 — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER George R. Gaither

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Rebecca Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Gen. Chas. D. Gaither

(Address) 1200 N. Charles St

15 Filed DEC 2 - 1924 ROBERT N. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Nov 30, 1924, that I last saw him alive on Nov 30, 1924, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Guston Pearre, M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Dec 2nd 1924

20 UNDERTAKER: Henry W. Jenkins & Son Co

ADDRESS: Richard & McCulloh

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92523

CERTIFICATE OF DEATH.

161-001

D 92523

Registered No.....

1-PLACE OF DEATH Women's Hosp. 14

City of BALTIMORE: (No.....St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby S. Stump

(a) Residence No. New Cathedral Md. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-1-24

7-AGE. .....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or 10 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant Female

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md (State or Country),

PARENTS.

10-NAME OF FATHER, Herman Stump

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Priscilla Dawson

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Priscilla Stump

(Address) New Cathedral Md

15- Filed DEC 3 1924 ROBT. R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-1-24

17- I HEREBY CERTIFY, That I attended deceased from 12-1, 19 24, to 12-1, 19 24, that I last saw h. alive on 12-1, 19 24, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

Unknown (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY None (Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam + Hist

(Signed) J. Arthur Work M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lorraine Cem	Dec 3 19 24
20-UNDERTAKER,	ADDRESS
Denny & Eckels Sons	McCulloh St Baltimore

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1001 ✓ D 92524

D 92524

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ~~WARD~~)

2-FULL NAME Elmer Lawson

(a) RESIDENCE NO. Elliott City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Robert Lawson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Church

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Mary Land

14 Informant Hospital Record
(Address)

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
DEC 2 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-24

17 I HEREBY CERTIFY, That I attended deceased from 11/28/24, 19..... to 12/1/24, 19..... ,
that I last saw h~~e~~ alive on 12/1/24, 19..... ,
and that death occurred, on the date stated above, at 4. a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

.....

.....

.....(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY
(Secondary) .....(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Lollery M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Gilboa Cem	Dec 4 1924
20 UNDERTAKER Easton Bros	ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Fuem

D 92525

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1023 S Sharp St St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodor Fuem

(a) Residence No. 1023 S. Sharp St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 7 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of—

6-DATE OF BIRTH (month, day and year) Nov 9/24

7-AGE, ...yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jesse Fuem

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Eugie Jackson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Cambridge Md

14- (Informant) Eugie Jackson

(Address) 1023 S. Sharp St

15- Filed DEC 2 - 1924 Registrar.

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 30, 1924 to Dec 1, 1924

that I last saw him alive on Dec 1, 1924

and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

6 Days

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Cook, M. D.

, 19 (Address) 615 N. Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 2, 1924

20-UNDERTAKER, Wm Geo W Hofer — ADDRESS 406 W Conway St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

176 027 1, 92

161-901 D 92526

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 9 WARD)

2-FULL NAME Charles C haney Jr

(a) RESIDENCE NO. Gorsuch Ave Abbotton WARD 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) #

(c) Name of employer #

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Beatrice E Haney

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar Burial Permit Clerk

DEC 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1924. to Nov 25, 1924.

that I last saw him alive on Nov 25, 1924,

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kerper, M. D.

12/1/24 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Director of Health. ADDRESS DEC 2-1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

175897 Bed

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92527

CERTIFICATE OF DEATH.

161-001 D 92527

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Adler

(a) RESIDENCE NO. 1510 N. Smallwood ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Oct. 30 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None pd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 2 1924, 19 .... Registrar. ROBERT R. KRAUTER, Burial Permit Clerk.

2000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1924 to Nov. 19 1924, that I last saw her alive on Nov. 19, 1924, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos 19 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edmund H Kemp, M. D.

11/21, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER ..... ADDRESS	JOHNS HOPKINS HOSPITAL, Commissioner of Health, DEC 2-1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92528 113 D 92528

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Williams

(a) RESIDENCE NO 829 Bevan St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of xxxx

6 DATE OF BIRTH (month, day, and year) Aug/1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Johns Hopkins Hospital
(Address)

15 Filed DEC 2 - 1924 192 ROBERT R. KRAUTER, Registrar

3/5

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestion

Probale Pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] (Coroner.), M. D.

Nov 24/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER [illegible] Health.

ADDRESS DEC 2 - 1924

Per. Wm. E. WOODALL.

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92529

161-001

D 92529

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Josephine ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Lee

(a) RESIDENCE NO. 637 Josephine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life hours ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/29/24

7 AGE — Years — Months — Days — If LESS than 1 day, 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jo. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Martha Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Martha Lee
(Address) 637 Josephine ST. JOHNS

15 Filed DEC 2 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1924, to ——, 19——, that I last saw him alive at 8 A.M. Nov 29, 1924, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) M. Alexander Wolfe M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: DEC 2 1924

UNDERTAKER: Com'r Health, — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 92530

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U S Marine Hosp. ST., 110 1/2 WARD)

2-FULL NAME Christian Johnson

(a) RESIDENCE NO. U S Marine Hosp ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed DEC 2 - 1924 ROGER R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct ....., 1924, to Nov 29 ....., 1924.

that I last saw him alive on Nov 27 ....., 1924.

and that death occurred, on the date stated above, at 1930 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis, Syphilis

Pneumonia Atonic

(duration) yrs. 0 mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia Atonic

(duration) 11 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? U S Marine Hosp.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Physical findings

(Signed) J. C. Francis, M. D.

11/30, 1924 (Address) U S Marine Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Trinity Cemetery

DATE OF BURIAL 12/2 1924

20 UNDERTAKER Joe Leisson & Bro

ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 92531

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp #1 ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matto Laevalampi

(a) RESIDENCE NO. 1639 Thames ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records
(Address)

15 Filed DEC 2 - 1924 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Hornung, M. D.
(Coroner.)

Dec. 1924 (Address) 1632 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Trinity Cemetery — DATE OF BURIAL 12/2 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E. Baltimore St

Should be stated EXACTLY. PHYSICIANS should fill mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92532

CERTIFICATE OF DEATH.

161-001 D 92532

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cecil Rupp

(a) RESIDENCE No. Riverside Ave. Essex, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Rupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine Winkler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Catharine Rupp

(Address) Essex, Md.

15 [illegible] ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

DEC 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 19 24 to Nov. 30, 19 24,

that I last saw her alive on Nov. 30, 19 24,

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec 2 19 24
20 UNDERTAKER	ADDRESS
Lilly & Zeile	to 3 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Gillery

D 92533

111-001

CERTIFICATE OF DEATH.

D 92533

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Miller

(a) RESIDENCE NO. 1431 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma E Miller

6 DATE OF BIRTH (month, day, and year): Feb 23 1873

7 AGE: Years 51 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Meeles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Catherine Slagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: University Hospital Records (Address)

15 Filed DEC 2 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-30 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Nov 30, 1924, that I last saw him alive on Nov 30, 1924, and that death occurred, on the date stated above, at 3.40 a.m.

The CAUSE OF DEATH* was as follows:

Emphysema, Gunture upper extremities, Preceded by an operation for a gastric ulcer,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

Nov 31, 1924 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Nov 24-1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W Wallace Walker, M. D.

, 19 (Address) University Hospital Lombard & Greene Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill. DATE OF BURIAL: 1-3 1924

20 UNDERTAKER: E & B Hahn ADDRESS: 115 E Mart St

Spec.—1-10-21—M&T—1500 Bks.

D 92534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Poplar Grove ST. 16 WARD)

2-FULL NAME Arthur C. Dietrich

(a) RESIDENCE NO. 1431 Poplar Grove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Virginia M. Dietrich

6 DATE OF BIRTH (month, day, and year) Oct. 27 - 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wall Paper

(b) General nature of Industry, business, or establishment in which employed (or employer) Business

(c) Name of employer

9 BIRTHPLACE (city or town) Davenport (State or country) Iowa

PARENTS

10 NAME OF FATHER Lus H Dietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Elizbet Fisher

13 BIRTHPLACE OF MOTHER (city or town) Erie (State or country) Penna

14 Informant Mrs. Virginia Dietrich

(Address) 1431 Poplar Grove St

15 Filed DEC 2 - 1924 19 ROBERT R. KRAUTER, Burial Permit (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1924, to Nov. 30, 1924, that I last saw him alive on Nov 30, 1924, and that death occurred, on the date stated above, at 10 10 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Organic Heart disease
Mitral Insufficency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Diagnosis

(Signed) Jane Brown, M. D.

12/1, 1924 (Address) 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	12-3 1924
20 UNDERTAKER Wm. Chas A. G. Robbins	ADDRESS 11 Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92535 141 D 92535

CERTIFICATE OF DEATH.

D 92535

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 8 WARD)

2-FULL NAME Mary Grimes

(a) RESIDENCE NO. 2317 E. Chase St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Claude Grimes Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Alvie Tarlton

11 BIRTHPLACE OF FATHER (city or town) Solomons Island
(State or country) St. Marys County, Md.

12 MAIDEN NAME OF MOTHER Anna E. Steen

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Claude Grimes
(Address) 2236 E. Biddle St.

15 Filed ..... 19 ..... Registrar Robert P. Harrison

EC2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1924, to Dec. 2, 1924, that I last saw her alive on Dec 2, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

1 Gen'l Tuberculosis
2 Uremia

(duration) 4 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pelvic Abscess (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 26/24

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adolf Lundheimer, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bal Cemetery

DATE OF BURIAL Dec 4 1924

20 UNDERTAKER Robt Bonser Sr

ADDRESS 2742 Fleet

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92536

CERTIFICATE OF DEATH.

Registered No. 179

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 S. Bouldin St. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Waytowitz

(a) Residence No. 711 S. Bouldin St. St., 76 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Watowitz

6-DATE OF BIRTH (month, day and year) June 11-1852

7-AGE. 72 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hacksmith 906

(b) General nature of industry, business, or establishment in which employed (or employer) A. Weiskittle Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Jacob Waytowitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mary Watowitz

(Address) 711 S. Bouldin St.

15- Filed DEC 2 1924

16- Robert F. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov 30-1924

17- I HEREBY CERTIFY, That I attended deceased from 11/26, 1924, to 11/30, 1924, that I last saw h. in alive on 11/30, 1924, and that death occurred, on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lung

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/1/1924 (Address) 633-5-32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL, Dec. 3rd 1924

20-UNDERTAKER, Lilly & Ed Zeiler ADDRESS 4038 Wolfe St

Spec—12-23-21—E.B.R.S.—400 Bks.

92537

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92537

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp St., 26 Ward) 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Lefts

(a) Residence No. 813 South Bolden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Eckes.

6-DATE OF BIRTH (month, day and year) Unknown - 1852.

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ger.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ger.

14- (Informant) Charles G. Zeiler

(Address) 700 S. 3rd St.

15- Filed ..... 192.... Registrar.

DEC 2 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 30-1924

I HEREBY CERTIFY, That I attended deceased from Nov. 29 19 24 to Nov. 30 19 24

that I last saw her alive on Nov 30 19 24

and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Femoral Hernia

Intestines and Uremia

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Thyreoiditis.

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 29/24

Was there an autopsy? no

What test confirmed diagnosis? Clin. & Phys. test

(Signed) Geo B Dyckert M. D

19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart Cem DATE OF BURIAL. Dec 3 19 24

20-UNDERTAKER, Lilly & Zeiler ADDRESS 403 S. Wolfe St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92538

128

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 912 Ryan St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John M. Bruce

(a) Residence No. 912 Ryan St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of, Mary E. Neipert

6-DATE OF BIRTH (month, day and year) Jan 26 1844

7-AGE. 30 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Truckster 045
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. John M. Bruce.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Louisa Serrano

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Mrs. Mary E. Bruce
(Address) 912 Ryan St.

15- Filed ..... Robert P. Harrison, Registrar.

DEC 2 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 13, 1924 to Nov. 30, 1924 that I last saw him alive on Nov 29, 1924 and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) 1 yrs. X mos. 18 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Maley Hoag M. D.

Dec 2. 1924 (Address) 729 Linden Ave Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Dec 3 1924

20-UNDERTAKER. Edgar F. Conway & Sons ADDRESS 701 Baltimore

B.—WRITE PLAINLY, WITH UNFADING INK—THIS ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92539

CERTIFICATE OF DEATH.

24 X 90

D 92539

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Belt Ave. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dietrich Tietjen.

(a) RESIDENCE NO. Roseville, N.J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXX HUSBAND of (XXXXXXX Johanna G.Tietjen.

6 DATE OF BIRTH (month, day, and year) February 17,1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sugar sampler.
(b) General nature of industry, business, or establishment in which employed (or employer) Czarnikow-Rionda Co.
(c) Name of employer New York.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Tietjen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Umland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Johanna G. Tietjen. (wife)
(Address) Elizabeth, N. J.

15 Filed DEC 2 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. d

CONTRIBUTORY (Secondary) (duration) yrs. mos. d

(Signed) Otto Reinhardt, M. D. (Coroner.)

Dec, 2nd. 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., d

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elizabeth N.J. Via American Railway Express	Dec 2 192
20 UNDERTAKER John F. Denny	ADDRESS 715 Eigh

Spec.—1-10-21—M&T—1500 Bks.

B 4446
B 92540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+69 D 92540

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7 ST., WARD)

2-FULL NAME Clara Mousley

(a) RESIDENCE NO. Eastern Ave & Ext. ST., Essex Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles P Mousley

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Little Creek Del

PARENTS

10 NAME OF FATHER Fred Whelehead

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 2 - 1924, 19 Robert P. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1924, to Dec 1, 1924,

that I last saw her alive on Dec 1, 1924,

and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of Dec 1, 1924

Was there an autopsy? No Blood Studies

What test confirmed diagnosis?

(Signed) Julian D Taylor M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del — DATE OF BURIAL Dec 5 1924

20 UNDERTAKER John F. Denny — ADDRESS 115 Light St

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92541

D 92541

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3445 Falls Road St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Gibson

(a) Residence No. 3445 Falls Road St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie E Gibson

6-DATE OF BIRTH (month, day and year) Feb 11 - 1852

7-AGE. 72 yrs. 9 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Balto City

PARENTS.

10-NAME OF FATHER. James F Gibson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Harford Co Md

12-MAIDEN NAME OF MOTHER. Emmetta Sanders

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Harford Co Md

14- (Informant) Mrs Clara Gibson

(Address) 3445 Fall Road

15- DEC 3 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) DEC - 1 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept ....., 1922, to Dec 1 ....., 1924, that I last saw him alive on Nov 30 ....., 1924, and that death occurred, on the date stated above, at 1-30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral arterio sclerosis

Senile dementia

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) ..... yrs. 2 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Unsmith, M. D.

Dec 2, 1924 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet

DATE OF BURIAL. Dec 3, 1924

20-UNDERTAKER. A S Marshall

ADDRESS 3539 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 92542

CERTIFICATE OF DEATH.

D 92542

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1146 Hull ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Martinmack

(a) RESIDENCE NO. 1146 Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	—	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Martinmack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Dora Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant John Martinmack (Address) 1146 Hull St.

15 DEC 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1924, to Dec. 1, 1924, that I last saw h[illegible] alive on Nov. 27, 1924, and that death occurred, on the date stated above, at 10 o'clock p. m.

The CAUSE OF DEATH* was as follows:

Marasmus, immunization

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs and symptoms

(Signed) Harry P. Warfield M. D.

, 19 (Address) 1373 Gallows Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Co.

DATE OF BURIAL Dec 3 1924

20 UNDERTAKER Chas. L. Stevens

ADDRESS 1501 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH D 92543

REGISTERED NO. D 92543

CITY OF BALTIMORE: (No. 426 N. Central St. ward 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thomas

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			Two	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Nelson Thomas

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Cora Richardson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed DEC 3 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1924 to Oct. 12, 1924 that I last saw him alive on Oct. 12, 1924 and that death occurred, on the date stated above, at 9 00 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? E L Stone

(Signed) ..... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner of Health. — ADDRESS: DEC 3 - 1924

Per. Wm. B. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D 92544

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp'l WARD) 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Henson

(a) RESIDENCE NO. 507 Bloom st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Not known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	68?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland ?

PARENTS

10 NAME OF FATHER Samuel Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susan platter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 Filed DEC 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1923 to Dec. 1, 1924, that I last saw her alive on Dec. 1, 1924, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cardiac Failure

Chronic infectious arthritis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Decubitus ulcers

Cataracts (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Schorr M. D.

12-2, 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem'y	12-4 1924
20 UNDERTAKER Helen A. Holland	ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92545

CERTIFICATE OF DEATH.

100-001

D 92545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Homewood Ave ST., 10 WARD)

2-FULL NAME Catherine E. Hart

(a) RESIDENCE NO. 1036 Homewood Ave ST., 10 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Clinton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Thomas Hart.
(Address) 1036 Homewood Ave

15 Filed DEC 3 - 1924 19 Keith R. Kramer Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 19 24, to Dec 2, 19 24,
that I last saw h. alive on Dec 2, 19 24,
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt E Ellbert M. D.

Dec 3, 1924 (Address) 1912 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 4 1924
20 UNDERTAKER Henry Hoeck & Son	ADDRESS 1306 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92546

CERTIFICATE OF DEATH.

129 D 92546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 E. Monument ST., 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Zimmerman

(a) RESIDENCE NO. 1203 E. Monument ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Zimmerman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
abt	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Jos. Zimmerman

(Address) 1203 E Monument

15 Filed DEC 3 - 1924, 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1924, to Dec 3, 1924, that I last saw her alive on Dec 2, 1924, and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:

Brain Fever

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Cerebral Cerosis with Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. T. Zimmerman M. D.

12/5, 1924 (Address) 2858 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 6 1924
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92547 — 129 — D 92547

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. 27th ST., 12 WARD)

REGISTERED No. D 92547

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann. E. Byrnes

(a) RESIDENCE No. 121 N. 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? 66 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Matthew M. Byrnes

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
about	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Matthew M. Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Anna E Carey

(Address) 121 N 27th St

15 DEC 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10 1924 to Dec 2 1924

that I last saw her alive on Dec 2 1924

and that death occurred, on the date stated above, at 10:32 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. few mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. A. Richardson, M. D.

Dec 3 1924 (Address) 1112 N. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 5 1924
20 UNDERTAKER	ADDRESS
Henry Horde Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92548

CERTIFICATE OF DEATH.

D 92548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Elder Alley ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Tiggell

(a) RESIDENCE No. 807 Elder Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Beatrice Tiggell

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Beatrice Tiggell
(Address) 807 Elder alley

15 Filed DEC 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping cough.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 2, 1924 (Address) 280 Cambridge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem. DATE OF BURIAL Dec 3 1924

20 UNDERTAKER Samuel Hinsley ADDRESS 678 Bdle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A K O D

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92549

CERTIFICATE OF DEATH.

101 D 92549

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 415 N. Fremont Ave (St.) 17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Hedges

(a) RESIDENCE NO. 415 N. Fremont Ave (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip Hedges

6 DATE OF BIRTH (month, day, and year) Unknown, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or . min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Estep

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Hill

(Address) 1137 N. Fremont Ave

15 Filed DEC 3 1924 19.. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1924, to Nov 30, 1924, that I last saw her alive on Nov 30, 1924, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) No Others

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Charles H. Fowler, M. D.

Dec 3 1924 (Address) 7101 Bank Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Dec 3 1924

20 UNDERTAKER Samuel J Brinsley ADDRESS 1128 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1624 Monroe St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Clellan Dilke Jr

(a) Residence No. 1624 N. Monroe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. 3 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 29. 1924

7-AGE. ..... yrs. 3 mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo. Clellan Dilke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. J.

12-MAIDEN NAME OF MOTHER, Natalie Wilman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Calloway

14- (Informant) Natalie Dilke
(Address) 1624 N. Monroe St

15-
Filed ..... 192.....
DEC 3 - 1924 ROGER T. KRAMER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 2-1924

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1924 to Dec 2 1924

that I last saw h alive on Mon Nov 30 1924

and that death occurred, on the date stated above, at 4 00 a.m.

The CAUSE OF DEATH* was as follows:

Cholera-cyanotic

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Jonnie Ebaugh M. D.

Dec 2 1924 (Address) 701 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cem	Wed 4 1924
20-UNDERTAKER.	ADDRESS
Harry W Eblen	W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92551

CERTIFICATE OF DEATH.

129

D 92551

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 138 E Clement St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Albert C Tarleton

(a) Residence No. 138 E Clement St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tarleton

6-DATE OF BIRTH (month, day and year) July 7 1847

7-AGE 77 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) W. M. R. R. 0 6 2

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS:

10-NAME OF FATHER, Thos Tarleton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Phila, Pa

12-MAIDEN NAME OF MOTHER Babette Stalling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Mary R Tarleton

(Address) 138 E. Clement St

15- Filed DEC 3 - 1924 ROBERT S. KRAUTER, Registrar.

Asst. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1924 to Dec 1 1924

that I last saw h[illegible] alive on Dec 1 1924

and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) A Eichenlaub M. D.

, 19 (Address) 1412 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Solomons Island via B&A R.R. DATE OF BURIAL, Dec 3 1924

20-UNDERTAKER, John P. Denny ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92552

CERTIFICATE OF DEATH.

D 92552 (1132) — 90 — D 92552

REGISTERED NO.....

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

2-FULL NAME David Landy

(a) RESIDENCE NO. 2121 Callow Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Landy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocerie

(b) General nature of industry, business, or establishment in which employed (or employer) 0 St

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Landy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Mutenorm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris P Segall

(Address) 3901 Fourth Ave

15 Filed DEC 3 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1924, to December 2, 1924.

that I last saw h alive on December 2, 1924.

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 15 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & lab.

(Signed) Isidor I. Frey, M. D.

Dec. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd — DATE OF BURIAL 12/3 1924

20 UNDERTAKER Jos Levinson & Bro — ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92553

CERTIFICATE OF DEATH.

161-001 D 92553

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 Dolphin St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mc Cormick

(a) Residence No. 117 Dolphin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 27-1924

7-AGE. — yrs. — mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER Chas Mc Cormick

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto.

12-MAIDEN NAME OF MOTHER Martha Nastvogel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto.

11- (Informant) Chas Mc Cormick

(Address) 117 Dolphin St.

15- Filed DEC 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1924 to Dec 3 1924

that I last saw her alive on Dec 2 1924

and that death occurred, on the date stated above, at 6 00 a m.

The CAUSE OF DEATH* was as follows:

congenital debilities

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Premature 6½ mo.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) [illegible] M. D.

, 19 (Address) 2421 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Peters Cemetery

DATE OF BURIAL. Dec 3- 1924

20-UNDERTAKER. Chas F. Graustson

ADDRESS 1180 W Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3/69

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92554 CERTIFICATE OF DEATH.

44 D 92554

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

2-FULL NAME Walter Fabb

(a) RESIDENCE NO. 722 Reynolds Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Fabb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Municipal Hospital Baltimore (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 3 - 1924, 19 ROBERT R. KRAUTER Registrar

BOC Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-21, 1924, to 11-29, 1924

that I last saw him alive on 11-29, 1924

and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Pellagra

Carcinoma of Stomach

(duration) yrs. 4 mos (Hosp.)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude G. Drane, M. D.

11-30 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health, Per. Wm. E. WOODALL

ADDRESS DEC 3 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92555 CERTIFICATE OF DEATH. 38 D 92555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Cole

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Philip Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Municipal Hospital Record (Address)

15 Filed ..., 19.. Burial Permit Issued ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): 11-30 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-24, 1924, to 11-30, 1924, that I last saw him alive on 11-30, 1924, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis, Aortic Insufficiency, Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub.

(Signed) Claude S. Stone, M. D.

11-30, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Dept. of Health. DEC 3 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4/28

DEC 1924

Cor.—1-12-23—M&T—100 Bks.

D 92556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92556

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S. Curley ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Bzowicz

(a) RESIDENCE NO. 600 S. Curley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
24	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Stanislaus Kaminski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Stanislaus Wisniewski
(Address) 600 S. Curley St.

15 Filed DEC 3 - 192 [illegible] Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Tbc. Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner)

Dec 3 192 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Dec. 4 1924
20 UNDERTAKER Stephen J. Fialkowski	ADDRESS 1000 S. Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—6-9-19—H. P. Co.—1000 Bks.

Keppler

D 92557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92557

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Reynolds ST. 24 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Kupper.

(a) RESIDENCE. No. 1414 Reynolds ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, ~~widowed~~, or divorced ~~HUSBAND~~ of (or) WIFE of Herbert Kupper.

6 DATE OF BIRTH (month, day, and year) May 2. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herbert Becker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Emma Burk

(Address) 1414 Reynolds

15 Filed DEC 3 - 1924 19 ROBERT R. KRAUTER, Registrar

Asst. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2. 1924

17

I HEREBY CERTIFY, That I attended deceased from July 15 . 1924 . to Dec 2 . 1924 . that I last saw h[illegible] alive on Dec 2 . 1924 , and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm. S. Gehring, M. D.

12-3. 1924 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	Dec 5. 1924
20 UNDERTAKER	ADDRESS 502
Wm Cook	E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92558 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76 D 92558

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3133 Calvert St., N W Ward)

(If death occurred in hospital or institution give its NAME instead of street and number.)

2-FULL NAME George Yerby Kerr

(a) Residence No. 3133 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. RESERVED FOR BINDING.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Kerr

6-DATE OF BIRTH (month, day and year) Dec 20-1862

7-AGE. 62 yrs. 7 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Loudoun (State or Country) Va

PARENTS.

10-NAME OF FATHER, Hugh L. Kerr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Annie E. Yerby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Mrs. Mary L. Kerr

(Address) 3133 N. Calvert St.

15-

Filed DEC 3 - 1924 ROBT. R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1924 to Dec 2nd 1924

that I last saw h[im] alive on Dec 2nd 1924

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visual

(Signed) H. Stanley Goosch M. D.

(Address) 2900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Northam Va DATE OF BURIAL Dec 5 1924

20-UNDERTAKER, Veltram & Hoe ADDRESS 1123 N. Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3300 Foster Ave. St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Howard Milton Lynch

(a) Residence No. 3300 Foster Ave. St., 76 Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Lynch.

6-DATE OF BIRTH (month, day and year) April 4-1888

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)..... Balto Copper Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John T. Lynch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Sarah E. Parsons.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14-(Informant)..... Ida Lynch

(Address)..... 3300 Foster Ave

15-Filed DEC 3 - 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 1-1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 7-1924 to Dec 1-1924

that I last saw h[illegible] alive on Dec 1-1924

and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

I. B. Pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Dorsey M. D.

(Address) 719 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Clint. DATE OF BURIAL, Dec. 3rd 1924

20-UNDERTAKER, Lilly & Zeile ADDRESS 403 S. Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92560

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

181 D 92560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Declared dead at St. Joseph Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Connor

(a) RESIDENCE No. 1038 E. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Potter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Rogers Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine Rytina
(Address): 2600 E. Balto. St

15 Filed DEC 3 - 1924 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said H/S (Inquest, autopsy or inquiry.) find that said deceased came to HIS death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphization -stop cock on fixture opeb- accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Collins, M. D. (Coroner.)

12/3/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 1924

20 UNDERTAKER: Wendell Dippel & Son — ADDRESS: 37 S

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE TION is very important. See instructions on back of certificate.

ec—12-23-21—E.B.R.S.—400 Bks.

D 92561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2904 Parkside Drive St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hoffmann

(a) Residence No. 2904 Parkside Drive St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis Hoffmann

6-DATE OF BIRTH (month, day and year) March 31. 1865

7-AGE. 59 yrs. 8 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. F. Oefter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Marie Janzow.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Louis Hoffmann (Address) 2904 Parkside Drive

15- DEC 3 - 1924 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2. 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 30th, 1924 to Dec 2nd 1924

that I last saw h[illegible] alive on Dec 1st, 1924

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia due to Cerebral Hemorrhage

(Duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Chronic Endocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ?

(Signed) Jefferson Buell M. D.

12/3 1924 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cremation DATE OF BURIAL, Dec. 5 1924

20-UNDERTAKER. Mrs. Mrs John H. Deufel & Son ADDRESS 801 N. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92562

CERTIFICATE OF DEATH.

73

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Dr. Charles Mezger

(a) RESIDENCE NO. 1501 W. Lanvale St WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Mezger

6 DATE OF BIRTH (month, day, and year) Nov. 14 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist 055

(b) General nature of industry, business, or establishment in which employed (or employer) Dentist

(c) Name of employer Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Gottlieb Mezger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Zeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record
(Address)

DEC 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2/24

17

I HEREBY CERTIFY, That I attended deceased from 11/28/24, to 12/2/24. 19 ,

that I last saw h[illegible] alive on 12/2/24. 19 ,

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Myelitis Transverse

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Heller, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec. 5 1924
20 UNDERTAKER	ADDRESS
Kurtz Bros. J. W. Teufel & Son	801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92563

CERTIFICATE OF DEATH.

101-001 D 92563

D 92563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2616 Hudson ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANCES ANUSZEWSKI,

(a) RESIDENCE NO. 2616 Hudson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 36 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Anuszewski,

6 DATE OF BIRTH (month, day, and year) September 19-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) House work at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER ------- Hojnacki,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Stefan Anuszewski,

(Address) 2616 Hudson Street

15 Filed DEC 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1924, to Dec. 2, 1924, that I last saw her alive on Dec. 1, 1924, and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible] M. D.

12/3/24 (Address) 408 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Dec. 5th, 1924.

20 UNDERTAKER M. Sadowski

ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 92564

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 92564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 E. Lanvale ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Osborn

(a) RESIDENCE NO. 28 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12/1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Edwin S Hurt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary S. Bowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss E. Hurt

(Address) 28 E Lanvale St

15 Filed ....., 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1924, to 12/2, 1924.

that I last saw h[illegible] alive on 11/24, 1924.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Aortitis with Myocardial Insufficiency

(duration) yrs. 10 mos [illegible] ds.

CONTRIBUTORY (Secondary) Gradual senility with Changes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

(Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 4 1924

20 UNDERTAKER C. E. Franck

ADDRESS 502 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PC3 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92565 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92565

CERTIFICATE OF DEATH.

Registered No. 9

1-PLACE OF DEATH

City of BALTIMORE: (No. 628 S. Streeper St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter. Kowalski

(a) Residence No. 628 S. Streeper St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 7 1921

7-AGE: 3 yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Peter . Kowalski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Josephine Legacinska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-

(Informant): Mr. Peter . Kowalski

(Address): 628 .S. Streeper Street

15-

Filed DEC 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 23d 1924 to Dec 2nd 1924

that I last saw him alive on Dec 2nd 1924

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A T Ray M. D.

Dec 3rd 1924 (Address) 24 S. Bonding

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Dec 4 1924

20-UNDERTAKER: John A Weber ADDRESS 1803 Bank St

GPO 8—WHITE PAPER. Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92566 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 320 E. Albemarle St., 3 Ward)

Registered No. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Scala

(a) Residence No. 320 E. Albemarle Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Pietro Scala

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Scala

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Victoria Landino

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Mary Scala

(Address) 320 E. Albemarle

15- Filed DEC 3 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 1. 1924

17- I HEREBY CERTIFY, That I attended deceased from 12-1 1924 to 12-1 1924 that I last saw him alive on 12-1 1924 and that death occurred, on the date stated above, at 1230 p.m.

The CAUSE OF DEATH* was as follows:

Arterial Hypertension

Chronic Arterio sclerosis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac-Renal Failure (Duration) 1 yr. — mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Demarco M. D.

12-3. 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 4. 1924
20-UNDERTAKER.	ADDRESS
Wendel Poppleton	37 Hanover

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item must be written PLAINLY, WITH UNFADING INK—THIS N.B.—WRIT... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S mation should be in plain terms, so that it may be properly classified. Exact statement of OCCU- CAUSE OF DEATH is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 D 92567

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1847 Belt Ave. ST. 24 WARD)

2-FULL NAME Charles Miller.

(a) RESIDENCE NO. 1847 Belt Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of (or ~~WIFE of~~) Madeline Miller.

6 DATE OF BIRTH (month, day, and year) June 30, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter. 015
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Madeline Miller.(wife). (Address) 1847 Belt Ave.

15 Filed DEC 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2nd. 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.
Congestion of the Lungs and Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto W. Reinhardt, M. D. (Coroner.)

Dec. 3, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. a.a.co. md. 5072

DATE OF BURIAL Dec 4 1924

20 UNDERTAKER Wm. Cook & Sons

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92568

CERTIFICATE OF DEATH.

D 92568

1-PLACE OF DEATH

City of BALTIMORE: (No. 1528 Baldwin St Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E Brothers

(a) Residence No. 1528 Baldwin St Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Nelson Brothers

6-DATE OF BIRTH (month, day and year) Apl 9 1863

7-AGE. 61 ....mos. ....ds.

If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14-(Informant) Nora Bozman

(Address) 1528 Baltimore St

15-

Filed 1924

Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 30th 1924 to Dec 2nd 1924

that I last saw h.. alive on Nov 2nd 1924

that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage.

Following possible ulcer or Probable Malignancy?

(Duration) yrs. mos. 2½ ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) T. J. Gilliss M. D.

12/3, 1924 (Address) 1527 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Mount Zion — DATE OF BURIAL. Dec 4 1924

20-UNDERTAKER. Cohenower & Son — ADDRESS 3617 Chestnut Ave

C3

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92569

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 1055 N. Gay St ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hunt

(a) RESIDENCE No. 1055 N. Gay St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walter H. Hunt

6 DATE OF BIRTH (month, day, and year) Dec 11/1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country) Md

PARENTS

10 NAME OF FATHER John P. Cunningham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Shaw

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.Y.

14 Informant Walter H. Hunt
(Address) 1055 N. Gay St

15 DEC 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1924, to Dec 2, 1924,

that I last saw her alive on Dec 2, 1924,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure
Probably yellow atrophy of the liver.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Undetermined.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Not completed yet.

(Signed) ... M. D.

12/3 1924 (Address) 1 E Man Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery.

DATE OF BURIAL Dec 5 1924

20 UNDERTAKER Walter Davis

ADDRESS 2307 Fairmount Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92570

CERTIFICATE OF DEATH.

101-001

D 92570

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 846 Hampson (St.) 1st (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Richards

(a) RESIDENCE. No. 846 Hampson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Wm Richards

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36 yrs ~~1888~~	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Bonnie Maley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Wm Richards (Address) 846 Hampson st

15 Filed DEC 4 - 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1924, to Dec 3, 1924, that I last saw h[illegible] alive on Dec 2, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) William A Stamo, M. D.

12/3, 1924 (Address) 1205 Pine Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fort Laurel Cem	12/4 1924

20 UNDERTAKER — ADDRESS

Jas W. Skinner 1625 O'Neal st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 92571

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Shakespeare ST., V WARD)

2-FULL NAME Milton J. Zochowski

(a) RESIDENCE NO 1613 Shakespeare ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16/19 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Josie Zochowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Czmil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Josephine Zochowski

(Address) 1613 Shakespeare St

15 DEC 4 - 1924 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Faulkner, M. D.
(Coroner)

Dec 4, 1924 (Address) 700 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 4 1924
20 UNDERTAKER	ADDRESS
F. W. Ozazewski	1930 Eastern

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

707 D 92572

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 954 Forest ST., 10 WARD)

2-FULL NAME Wesley Thomas

(a) RESIDENCE NO. 954 Forest ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) month and day unknown 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Family Contractor

9 BIRTHPLACE (city or town) (State or country) Stynburne Md.

PARENTS

10 NAME OF FATHER Tobe Thomas

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Abraham Thomas (Address) 954 Forest St Baltimore

15 Filed DEC 4 1924 ROBERT B. KRAUTER Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to Ans death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Base & Parietal Skull, by Blunt Instrument in hands of Unknown Man on bail of $1000 Accident (duration) ... yrs. ... mos. 7 hrs

CONTRIBUTORY (Secondary) Laceration & Contusion of Brain (duration) ... yrs. ... mos. ... ds.

(Signed) James M Fenton M. D.
(Coroner.)

Dec 2 1924 (Address) 900 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Branch Md DATE OF BURIAL Dec 4 1924

20 UNDERTAKER J H Braun & Son ADDRESS 1080 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 09 D 92573

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 E. Madison St ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Smith

(a) RESIDENCE NO 1633 E. Madison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Dec 23/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	1	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edward Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Marie Daingerfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Marie Smith (mother)
(Address) 1633 E. Madison

15 Filed ..., 192... ROBERT R. KRAUTER, Registrar.
DEC 4 1924 Assist. Public Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Bronchopneumonia (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Mallon, M. D. (Coroner)

12/4/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cem	Dec 8th 24
20 UNDERTAKER	ADDRESS
J. L. Blum & Son	108 Monroe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 9 D 92574

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 210 N. Fulton Ave. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Gonter

(a) RESIDENCE NO. 210 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Gonter

6 DATE OF BIRTH (month, day, and year) May 5 1845

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	79	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Thurmont

(State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Joseph Freeze

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Rouzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs Alexander M. Meredith

(Address) 710 N. Fulton ave

15 Filed DEC 4 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from November 1924 to Dec 2nd 1924, that I last saw h[illegible] alive on Dec 2nd 1924, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Bryant, M. D.

, 19 (Address) 1601 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Md

DATE OF BURIAL Dec 4 1924

20 UNDERTAKER Chas. G. Black

ADDRESS 747 W. Lanvale ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92575

CERTIFICATE OF DEATH.

12 9 D 92575

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 N. Broadway ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Cohn

(a) RESIDENCE NO. 207 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Cohn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1492 Bala

15 Filed DEC 4 - 1924 ROSCOE R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1924, to Dec. 3, 1924, that I last saw h e alive on Dec. 2 1924, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Interst. Nephritis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sydney Wallenstein, M. D.

, 19 (Address) 2042 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Harmony

DATE OF BURIAL Dec 4 1924

20 UNDERTAKER Jack Lewis, 1492 E

ADDRESS Bala

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92576

CERTIFICATE OF DEATH.

1884-007

D 92576

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Memorial Hospital ST.) (WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha M. Susheck

(Residence in Baltimore: No. 416 Lake Ave Govans St.)

(yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... (Month) unknown (Day) ....., 1 ..... (Year)

AGE. Above 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Indianna

PARENTS.

10-NAME OF FATHER, William Major

11-BIRTHPLACE OF FATHER (State or Country) Indianna

12-MAIDEN NAME OF MOTHER Eliz. Vanpelt

13-BIRTHPLACE OF MOTHER (State or Country) Indianna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanor M. Race

(Address) 416 Lakeave Govans

15-

Filed ..... DEC 4 1924 ....., 191... ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December (Month) 2 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries Fractured Skull Car Accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison (Coroner.) M. D.

Dec 3 1924 (Address) 632 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Shelbyville Indianna	12/4 1924
20-UNDERTAKER	ADDRESS
Chas P. Crane & Son	118 W. Mt Royal Ave

Hopkins Apts. are at St. Paul & 31st. St.

Spec.—1-10-21—M&T—1500 Bks.

92577

HEALTH DEPARTMENT—CITY OF BALTIMORE

92577

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Bertha Stein Raffel

CITY OF BALTIMORE: (No. Hopkins Apartments ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Stein Raffel

(a) RESIDENCE NO. Hopkins Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob M. Raffel

6 DATE OF BIRTH (month, day, and year) Oct. 11th. 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Allegany, (State or country) Penna.

PARENTS

10 NAME OF FATHER Daniel Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Amelia Keyser

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. Arthur Raffel (Address) Hopkins Apartments.

15 Filed ..... 19 ..... Registrar

DEC 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd. 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 15, 19 24, to Dec 3, 19 24, that I last saw her alive on Dec 3, 19 24, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes - nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

12. 3, 1924 (Address) 2040 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cemetery — DATE OF BURIAL: 12/5/24

20 UNDERTAKER: David Sondheim — ADDRESS: 1620 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Burness.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92578

CERTIFICATE OF DEATH.

44 D 92578

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 222 Monastery Ave (ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian J Burness

(a) RESIDENCE No. 222 Monastery Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie C Burness

6 DATE OF BIRTH (month, day, and year) Sept 7 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	44	2	25	

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) McCall Printing Co

(c) Name of employer George C Horn

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm C Burness

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes Groninger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Annie C Burness

(Address) 222 Monastery Ave

15 Filed DEC 4 - 1924 ROBERT R. KRAFFT, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 16 1924 to Dec 2 1924

that I last saw h[illegible] alive on Dec 2 1924

and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) James L Crayton M.D.

(Address) 1724 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec. 6, 1924
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3109 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92579

CERTIFICATE OF DEATH.

161-001

D 92579

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1003 Sharp St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hurt

(a) Residence No..... St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, black

5-Single, Married, Widowed, or Divorced (Write the word.) infant

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-2-24

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 6 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto., Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Thomas Hurt

11-BIRTHPLACE OF FATHER (city or town) Virginia
(State or Country).

12-MAIDEN NAME OF MOTHER, Edna Legree

13-BIRTHPLACE OF MOTHER (city or town) Maryland
(State or Country).

14-

(Informant) Edna Hurt

(Address) 1003 Sharp St.

15-

Filed DEC 4 - 1924 ALBERT R. KRAUTER, Registrar.

369 30M 1-24 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2, 19 24 to Dec. 2, 19 24 that I last saw him alive on Dec. 2, 19 24 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Prematurity.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) M. Alexander Nover M. D.

, 19 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19..

20-UNDERTAKER, [illegible]

ADDRESS [illegible]

DEC 4 - 1924

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92580
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4253 Park Heights ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Olivia Russell

(a) RESIDENCE. No. 4253 Park Heights Ave ST.... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	-	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto - md
(State or country)

PARENTS

10 NAME OF FATHER John A Russell

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Olivia Linsley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John C Russell
(Address) 4253 Park Heights ave

15 Filed DEC 4 - 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1924, to Dec 4, 1924, that I last saw her alive on Dec 4, 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) James S. Hochheimer, M. D.

(Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 5th 1924

20 UNDERTAKER Geo. W. Little

ADDRESS 3700 Edmondson ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92581

CERTIFICATE OF DEATH.

160 D 92581

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1603 S. Clinton St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Yeager

(a) Residence No. 1603 S. Clinton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 11- 1924

7-AGE. ..... yrs. 2 mos. 23 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Chas F. Berkemyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Margaret E. Yeager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Margaret E. Yeager

(Address) 1603 S. Clinton St.

DEC 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1924 to Dec. 4 1924

that I last saw her alive on Dec. 3 1924

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Brownlee M. D.

12-4-, 1924 (Address) 3037 O'Donnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Dec 5 1924

20-UNDERTAKER,	ADDRESS
Zirkler & Zirkler	1739 E. Eager St.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92582

CERTIFICATE OF DEATH.

57 D 92582

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 N. Patterson Pk Ave. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Riley

(a) Residence No. 918 N. P. St. Pk. Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. W. Riley

6-DATE OF BIRTH (month, day and year) Nov 13/63

7-AGE. 61 yrs. — mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). at Home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Dr Wm H. Moore

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Susan E —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-

(Informant) Joseph W. Riley

(Address) 918 N. Pat. Pk. ave

15-

DEC 4 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/1/24

I HEREBY CERTIFY, That I attended deceased from 11-25 1924 to 12-1 1924

that I last saw h live on 12-1 1924

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Rupprecht M. D.

(Address) 400 N Mott Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Pk	12/4 1924
20-UNDERTAKER. Philip Hennig	ADDRESS 2016 Edmondson Ave

should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

TYPE

Spec.—12-23-21—E.B.P.S.—400 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92583

CERTIFICATE OF DEATH.

90 D 92583

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1425 Eutaw Place St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr John Theodore King

(a) Residence No. 1425 Eutaw Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 11 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Mary Gees King

6-DATE OF BIRTH (month, day and year) Dec 14 1845

7-AGE. 79 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John King

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER Hester Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mary Gees King

(Address) 1425 Eutaw Place

15- Filed DEC 4 - 1924 19.. Registered

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 2. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1924 to Dec 2 1924.

That I last saw him alive on Dec 2. 1924.

and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ✓ yrs. ✓ mos. 10 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) John T. King Jr. M. D.

, 19 (Address) 1208 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 4 1924

20-UNDERTAKER, How Cuttchell ADDRESS 1201 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEATH

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92584 — 90 ✓ — D 92584

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Durney

(a) RESIDENCE NO 708 N.Collington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Durney

6 DATE OF BIRTH (month, day, and year): June 20/1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	5	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Balto.Md

PARENTS

10 NAME OF FATHER: Louis F. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Clara Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.Md

14 Informant: Hebrew Hospital Record
(Address)

15 Filed ..., 192 ... ROBERT R. KRAUTER, Registrar
DEC 4 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Insufficiency

(Autopsy at Hebrew Hospital)

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Pregancy- 8 1/2 to 9 mons

(duration) yrs. mos. ds.

(Signed) J. M. Fuller, M. D.
(Coroner.)

12/3/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Dec 4 1924

20 UNDERTAKER: Wm. E. Fuller & Son — ADDRESS: 2334 Pitts St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 No. 92585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92585

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH U.S. Marine Hospital #1. Baltimore, Md

CITY OF BALTIMORE: (No. ... ST., 25 WARD)

2—FULL NAME John P. Lyons

(a) RESIDENCE NO. Coast Guard Cutter Bear ST. ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... ds. How long in U. S., if of foreign birth? ... yrs. ... ms. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 066

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.C. Guard

(c) Name of employer U.S. Coast Guard

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Coast Guard Sta.

(Address)

15 Filed DEC 4 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1924, to Dec 3, 1924,

that I last saw him alive on Dec 3, 1924,

and that death occurred, on the date stated above, at 6.35 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis Cerebro Spinal

due to Fracture of Skull

of. Coroner J. J. Mahoney

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Compound fracture Nasal bone

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? On board

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. A. Fiske M. D.

12/3 1924 (Address) U.S. Marine Hospital no 1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery

DATE OF BURIAL 12/4 1924

20 UNDERTAKER A. Levinson & Bro

ADDRESS 1124 E Balto st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Hampe

D 92586

HEALTH DEPARTMENT—CITY OF BALTIMORE

123 D 92586

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH St Jos Hospital

City of BALTIMORE: (No. 9 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Hampe

(a) Residence No. 1619 Laguette St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred, ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura F.

6-DATE OF BIRTH (month, day and year) Aug 11, 1845

7-AGE. 79 yrs. 3 mos. 17 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shirt Waist Op

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ... Cr + Co

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS

10-NAME OF FATHER. Jno Kunz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Jno Kunz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant) Wm F Farasse.

(Address) 505 Park Ave

15-DEC 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1924 to Dec 3 1924, that I last saw him alive on Dec 3 1924, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Gall Bladder
& Generalized Peritonitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (Duration) ... yrs. ... mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H B Sybert M. D

19 (Address) St Jos Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet-Dec 6 | DATE OF BURIAL, 1924

20-UNDERTAKER. Wm Cook | ADDRESS 502 E Fayette Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92587

CERTIFICATE OF DEATH.

100 001 ✓ D 92587

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2843 Greenmount Ave St.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David A. Coggins

(Residence in Baltimore: No. 2843 Greenmount Ave St.; 72 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. ..... May (Month) ..... 26 (Day), 1852 (Year)

7-AGE. ..... 72 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, George Coggins

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Williams

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence Coggins

(Address) 2843 Greenmount Ave

15- ROBERT R. KRAUTER,

Filed ..... 191... Deputy Registrar.

DEC 4 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 2 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1924, to Dec 2 1924, that I saw him alive on Dec 2 1924, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

1 Mitral Valvular Insufficiency

2 .....

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Wm J Fillebrown M. D.

Dec 3, 1924 (Address) 1118 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Parkwood	Dec. 5, 1924

20-UNDERTAKER	ADDRESS
H. M. Cook & Son	Station

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92588

CERTIFICATE OF DEATH.

90 D 92588

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 3918 Liberty Heights St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Schmidt

(a) Residence No. 3918 Liberty Heights St., ... Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 60 yrs. . mos. . ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Carolina Schmidt

6-DATE OF BIRTH (month, day and year) Aug-11-1841

7-AGE. 83 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). none
(c) Name of employer. none

9-BIRTHPLACE (city or town) (State or Country), unknown Germany

PARENTS.

10-NAME OF FATHER, Henry Schmidt

11-BIRTHPLACE OF FATHER (city or town) unknown (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Dorothea Wehn

13-BIRTHPLACE OF MOTHER (city or town) unknown (State or Country) Germany

14- (Informant) Carolina Schmidt (wife)
(Address) 3918 Liberty Heights

15- DEC 4 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec-2-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1924, to Dec 2, 1924, that I last saw h. alive on 6.15 P.M., 1924, and that death occurred, on the date stated above, at 6.20 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Disease

(Duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank L. Meyer, M. D.

(Address) 1500 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, Dec 4 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM S. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS In plain terms, so that it may be properly classified. Exact statement of OCCU instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92589

CERTIFICATE OF DEATH.

1314

1-PLACE OF DEATH St Josephs Hospital

Registered No.....

City of BALTIMORE: (No.....St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Walter

(a) Residence No. 3137 Abell Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 27th 1861

7-AGE. 63 yrs. mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chemist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna.

PARENTS

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14-

(Informant) Mrs. Wm. A. Walter

(Address) 3137 Abell Ave.

15-

Filed. 1924 ROBERT R. KRAMER Registrar.

DEC 4 - 1924

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/3/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Dec 3 1924 that I last saw h. alive on Dec 3 1924, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:.

Pyonephrotic abscess.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocard. Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 3/24

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) G. B Sybert M. D

. 19 (Address) St Jos Hosp. Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Druid Ridge Cemetery	12/6
20-UNDERTAKER,	ADDRESS
E.D. Fanning Son	1938 E. Lafayette Ave

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92590

CERTIFICATE OF DEATH.

D 92590

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3109 Oakfield Ave. St.) 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Margaret Kennedy

(Residence in Baltimore: No. 3109 Oakfield Ave St.; ..... yrs., 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Nov. ..... 16th ....., 1857.
(Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Ephriam Bennett.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Maring

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Kennedy

(Address) 3109 Oakfield Ave

15- Filed DEC 4 - 1924, ROBERT R. KRAUTER, Chief Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December ..... 3rd ....., 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1924, to Dec 3 1924, that I saw h[er] alive on Dec 3 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Dec. 3rd, 1924 (Address) 4218 Harford Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Sharptown Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Sharptown, Md.	12/4/1924

20-UNDERTAKER W. D. Graham & Bro. ADDRESS Sharptown, Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mc Guire ✓

D 92591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 128 D 92591

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S. Dallas ST.: 3 WARD)

2-FULL NAME Alice McGuire

(a) RESIDENCE. No. 27 S. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Color	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) No. 10

(c) Name of employer No

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sarah Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Theo. White
(Address) 113 S. Wolfe St.

15 Filed DEC 4 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19th, 1924, to Dec 1st, 1924,
that I last saw her alive on Dec 1st, 1924,
and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema 3 da

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul L Wimer, M. D.

12-2, 1924 (Address) 308 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Dec 5 1924

20 UNDERTAKER Theo. White ADDRESS 113 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

92592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D 92592

1-PLACE OF DEATH

City of BALTIMORE: (No. 2019 Bank St., 2nd Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick M Myers

(a) Residence No. 2019 Bank St., 2nd Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. — ds. How long in U. S., if of foreign birth? — yrs. 7 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 17th 1924

7-AGE. ....yrs. 7 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, Melvin F Myers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Lida Forster

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mr Fred Myers

(Address) 2019 Bank St

15- Filed DEC 4 - 1924 Robert R. Reuter, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/4/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 25, 1924 to Dec 1, 1924 that I last saw h... alive on Dec 4, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Colitis (Toxic)

(Duration) ....yrs. ....mos. 4 0 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

, 19 24 (Address) 332 S Patterson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore

DATE OF BURIAL, Dec 5th, 1924

20-UNDERTAKER, Peter Nicolaus

ADDRESS 2060 Eastern Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

December 4, 1924.

Dr. Daniel S. Fisher,
332 S. Patterson Park Ave.,
Baltimore, Maryland.

Dear Dr. Fisher:

We have before us the death certificate signed by you for a child, Frederick W. Myer, 2019 Bank Street, and you give as the cause of death Acute Ileo-colitis.

This case is on record in our Department as having had Pertussis and we are writing to kindly ask you to give us further information concerning the death of this child, either by writing same to us or by calling at this Department to see the Commissioner of Health.

Thanking you for a prompt report on this matter, we are,

Yours very respectfully,

G. Assistant Commissioner of Health.

PHONE WOLFE 3006
332 S. PATTERSON PARK AVENUE

BALTIMORE, MD., DEC 8 1924

Dr J Fredrick Hemple
Health Dept.

Dear Dr Hemple:-

Your letter of Dec 4th concerning information about the case of Fredrick Myer 2019 Bank St. is in hand.

This patient was primarily treated by Dr Joseph Cokorinos 2224 Ashland Ave about 9 weeks ago diagnosis made by Dr Cokorinos was Otio Otitis with a complicating pneumonia the Child was sent to the Mercy Hospital where it remained until about a week before its death. The Child was sent home from the hospital with what the parents

DR. DANIEL S. FISHER
PHONE WOLFE 8008
332 S. PATTERSON PARK AVENUE

BALTIMORE, MD.

termed a suspicious cough the nurse in charge explained to the mother that the intestinal condition was much improved when I was called to see the case the child was in a grave condition suffering from an Ileo Colitis with as high as 20 stools a day the child had a bronchitis but I could in no way associate the cough with that of pertussis the child was taken with intense gastro Intestinal symptoms convulsions lasting several hours followed by death.

In my three visits to see the patient my treatment was confined entirely to the Gastro Intest. tinal Condition and had no

DR. DANIEL S. FISHER
PHONE WOLFE 8006
332 S. PATTENSON PARK AVENUE

BALTIMORE, MD.

Association what one sick
pertusses of which I had made
no diagnosis.

Yours very Respectfully

Daniel S Fisher.

Spec—12-23-21—E.E.F.S.—400 Blks.

D 92593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92593

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1716 Thames St., K Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hugo Reiman

(a) Residence No. 1716 Thames St., 2 Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of the late Elizabeth Reiman

6-DATE OF BIRTH (month, day and year) May 30th 1842

7-AGE. 82 yrs. 6 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Barber

(b) General nature of Industry, business, or establishment in which employed (or employer). at Home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Gustav Reiman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant). Katharine J. Parker Daughter

(Address) 1716 Thames St

15- Robert F. Harrison,

Filed 1924 192 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 2nd 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26 1924 to Dec. 2 1924 that I last saw him alive on Dec. 2 1924 and that death occurred, on the date stated above, at 7 10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Bronchial)

(Duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Infirmities of age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John H. Rehberger M. D

19 (Address) 1709 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Cemetery

DATE OF BURIAL. Dec 5th, 1924

20-UNDERTAKER. Lilly & Gaile

ADDRESS 400 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 4 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92594

96

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Michaels Church St., Lombard & Wolfe Sts Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Gibmeyer Sr.

(a) Residence No. 2019 Fleet St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Gibmeyer

6-DATE OF BIRTH (month, day and year) Mch 19 1853

7-AGE. 71 yrs. 8 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Carpenter 15

(b) General nature of industry, business, or establishment in which employed (or employer) at St. Michaels

(c) Name of employer. Church

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Frederick Gibmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Cook

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Agnes Gibmeyer Wife

(Address) 2019 Fleet St

15- Filed DEC 4 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from DEC-1- 1924 to DEC-1- 1924

that I last saw h— alive on DEC 1 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Contrac Block. (Embolism) (Coronary)

(Duration) yrs. mos. 1/2 hr

CONTRIBUTORY (Secondary) Atheroma - (Vascular Septic Gangrene) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) John A Dorsey M. D

, 19 (Address) 725 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL. Dec 5th 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St

B—WRITE PLAINLY with pen and ink. NAMES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

John Omeara

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92595

100-09 92595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack O'Mara

(a) RESIDENCE NO. 813 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred More than 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): about 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): O/K

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Don't Know

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Reed

(Address) 892½ W. Lombard St

15 Filed DEC 4 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1924, to Dec 1, 1924, that I last saw h/M alive on Dec 1, 1924, and that death occurred, on the date stated above, at 7:20 p. m.

The CAUSE OF DEATH* was as follows:

Pachymeningitis Interna Hemorrhagica

(duration) ? yrs. ? mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Lowe M. M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ottawa Ill	Dec 4, 24
20 UNDERTAKER	ADDRESS
Harry H. Witzke	153 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. Information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92596

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

2-FULL NAME William Anderson

(a) RESIDENCE (Usual place of abode) No. 607 Salisbury Court ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C

PARENTS

10 NAME OF FATHER Joseph Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C

14 Informant Municipal Hospital Records JOHNS

(Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

[illegible] Permit Clerk.

3494 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-25 1924 to 11-30 1924

that I last saw him alive on 11-30 1924

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Cerebral Thrombosis

(Left Hemiplegia)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Dorsey, M. D.

11-30 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 4 1924

[illegible] Bureau of Health.

FOR WM. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92597

CERTIFICATE OF DEATH.

38 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Matthews

(a) RESIDENCE No. 108 Colvin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Bisk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Municipal Hospital Records
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 4 1924, Robert P. Harrison, 3018 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1 1924

17

I HEREBY CERTIFY, That I attended deceased from 10-22, 1924, to 12-1, 1924.

that I last saw him alive on 12-1, 1924.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; Aortic Insufficiency; Myocardial Insufficiency

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sx

(Signed) Claude S. Draper M. D.

12-2 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner of Health.	ADDRESS DEC 4

Per. Wm. E. Woodall

B.—WRITE PLAINLY, with ink. All items must be carefully supplied. AGE should be stated EXACTLY; PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 92598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92598

CERTIFICATE OF DEATH.

REGISTERED NO. 161-24

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 W Lanvale ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Baumgardner

(a) RESIDENCE. No. 1027 W Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of x

6 DATE OF BIRTH (month, day, and year) Dec 3 1924

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or min.
	x	x	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer x

9 BIRTHPLACE (city or town) (State or country) Butte Mont

PARENTS

10 NAME OF FATHER Wm J Baumgardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas

12 MAIDEN NAME OF MOTHER Josephine Bizek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Wm J Baumgardner
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 4 - 1924, 19 Robert P. Harrison, Registrar
2016 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924, to Dec 4, 1924, that I last saw him alive on Dec 3, 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY x
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? x Date of

Was there an autopsy? x

What test confirmed diagnosis?

(Signed) J Van Williams, M. D.

, 19 (Address) 931 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner of Health.

Per Wm. F. Roberts

DEC 4 - 1924

mation should be carefully supplied. AGE should be stated EXACTLY. FURNISH ... may be properly classified. Exact statement of OCCUPA... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92599

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92599

181-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Hudson St., 3 ST., ... WARD)

2-FULL NAME Mrs. P. Sullivan

(a) RESIDENCE No. 924 Hudson St., ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dont Know

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Bottle Washer
(b) General nature of industry, business, or establishment in which employed (or employer): 986
(c) Name of employer: Dont Know

9 BIRTHPLACE (city or town) (State or country): Dont Know

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Robert F. Sullivan

(Address) 924 Hudson St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental (Gas) Poisoning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Blake, M. D.

(Coroner.)

192 (Address) 25 E. Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: DEC 4 1924

20 UNDERTAKER: Commissioner Health,

ADDRESS

DEC 4 - 1924 THE MORGUE

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—160 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92600

CERTIFICATE OF DEATH.

D 92600

66

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Saulsbury St. WARD)

2-FULL NAME H no Spare.

(a) RESIDENCE NO. 1000 Saulsbury St. WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Val

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant .....
(Address)

15 Filed DEC 4 - 1924 192 Robert T. Harrison, Registrar

201 AT THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. ..... mos. ..... ds.

(Signed) Geo Edward Blake, M. D.
(Coroner.)

Dec 4 1924 (Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER Commissioner of Health, ADDRESS DEC4 - 1924

For Use of Undertaker

TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92601

92601

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Prospect Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Bortner

(a) RESIDENCE NO. 108 Prospect Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Bortner

6 DATE OF BIRTH (month, day, and year) Nov. 11- 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	59	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co, Maryland

PARENTS

10 NAME OF FATHER Noah Stockdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha A. Algire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John M. Bortner (Address) 108 Prospect Ave.

15 Filed DEC 4 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1924, to Dec 2, 1924, that I last saw h[illegible] alive on Dec 2, 1924 and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Interstitial Nephritis

Interval (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia Coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R B Norment, M. D.

12-4 1924 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Arcadia. Md

DATE OF BURIAL Dec. 5 1924

20 UNDERTAKER Grace H. Burgee

ADDRESS 360 Hollo Rd.

N. B.—WRITE CLEARLY. PENCILLED information should be carefully supplied. AGE should be stated EXACTLY. PHRASES such as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 92602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92602

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 N. Chester ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F. Wentz

(Residence in Baltimore: No. same — 1732 N. Chester St.; ...yrs.,...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 11, (Month) (Day) 1866 (Year)

7-AGE, 58 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Charles Wentz

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Margaret Schmidt

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine E. Wentz

(Address) 1732 N. Chester St.

15-

Filed ..., 192... Robert P. Harrison, Registrar.

C 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2d 1924, to Dec 7 1924, that I saw him alive on Dec 7 1924, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. ...ds.

(Signed) Henry F. Wentz M. D.

12-3, 1924. (Address) Roland Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, 12/5, 1924

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave

N.B.—CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Prince St, 17 Ward)

Registered No. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William E Alden

(a) Residence No. 815 Prince St, Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Color

5-Single, Married, Widowed, Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1889

7-AGE. 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (City or Town) (State or Country) Balto City Md

PARENTS.

10-NAME OF FATHER. Wm Alden

11-BIRTHPLACE OF FATHER (City or Town) (State or Country) Md

12-MAIDEN NAME OF MOTHER. Wm Alden

13-BIRTHPLACE OF MOTHER (City or Town) (State or Country) Md

14- (Informant) Eliz E Alden

(Address) 815 Prince St

15-

Filed DEC 4 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1924 to Dec 3 1924

that I last saw him alive on Dec 3 1924

and that death occurred, on the date stated above, at 10.9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By none

(Signed) J. R. Leadley M. D

, 19 (Address) 753 Edg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Owens Station

DATE OF BURIAL, 12-5-1924

20-UNDERTAKER. David Earle & Co

ADDRESS 716

Should be carefully typed. AGE should be properly classified. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92604

CERTIFICATE OF DEATH.

100-09 D 92604

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 756 W Lanvale ST., 4 WARD)

2-FULL NAME Mary Virginia Hayes

(a) RESIDENCE NO. 756 W Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas A. Hayes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Zetta Banks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant [illegible]
(Address) 756 W Lanvale St.

15 Filed DEC 4 - 1924, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cord

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

12-4-24, 192 (Address) 1111 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	12-5 192 24
20 UNDERTAKER Sam Kosh Son	ADDRESS 916

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See Instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92605

CERTIFICATE OF DEATH.

100-09 D 92605

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Broxton

(a) RESIDENCE No. 2019 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Frank Broxton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Municipal Hospital (Address)

15 Filed DEC 4 1924, 19 Robert ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 1 1924

17

I HEREBY CERTIFY, That I attended deceased from 11 - 17, 1924 to 12 - 1, 1924

that I last saw him alive on 12 - 1, 1924

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude C. Dixon, M. D.

12-1 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-6, 24
20 UNDERTAKER Hunt Parker	ADDRESS 916 Park Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE information should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92606

CERTIFICATE OF DEATH.

57 D 92606

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N Pine ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Owen Peaker

(a) RESIDENCE No. 518 N Pine ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 [illegible] Baltimore

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Florence Peaker

(Address) 518 N Pine St

15 Filed ..... 19.. Robert F. Harrison, Registrar

DEC 4 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-1924

17 I HEREBY CERTIFY, That I attended deceased (from Nov 29, 1924, to Dec. 3, 1924, that I last saw him alive on Dec. 2, 1924, and that death occurred, on the date stated above, at 4.05 A m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 0 yrs. 3 mos 3 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) R B Kenyon, M. D.

Dec 3 1924 (Address) 607 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12-6-24

20 UNDERTAKER David Earp

ADDRESS 916 Ca ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 92607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Whatcoat ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Brown

(a) RESIDENCE. NO. 820 Whatcoat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Brown

6 DATE OF BIRTH (month, day, and year): May 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Walter Brown

(Address):

15 [illegible] 1924 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 24 1924 to Dec 3 1924

that I last saw h[illegible] alive on Dec 3 1924

and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 3 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	12-6-24
20 UNDERTAKER	ADDRESS 916
[illegible]	

B.—WRITE PLAINLY. WITH INK. PHYSICIANS ... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... TION is very important. See instructions on back of certificates. ... OCCUP...

Cor.—1-12-23—M&T—100 Bks.

D 92608

HEALTH DEPARTMENT—CITY OF BALTIMORE

36 B 04 92608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Louis Beane

(a) RESIDENCE No 1211 Dukeland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Beane

6 DATE OF BIRTH (month, day, and year) Oct 12/1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manager
(b) General nature of industry, business, or establishment in which employed (or employer) Mfg. Refrigators
(c) Name of employer Roth Bros.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. J. Beane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hogg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Beane
(Address) 1211 Dukeland Ave

15 Filed DEC 4 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of kidney

(Autopsy at Hopkins Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Wallis, M. D.
(Coroner.)

12/4/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 5th 1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North Ave

mation should be carefully supplied. Any information which may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92609 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5108 Fernvale Ave St., 28 Ward) Registered No. 90

2-FULL NAME. William Moreland Cosh

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 5108 Fernvale Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jany 9-1841

7-AGE. 83 yrs. 10 mos. 24 ds. If LESS than 1 day, hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer), Gas Works

(c) Name of employer, Com. Gt Edw Co

9-BIRTHPLACE (city or town) (State or Country), Phila Pa

PARENTS.

10-NAME OF FATHER, Andrew Cosh

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Mary Reed

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Scotland

14- (Informant) Mrs Annie Cosh

(Address) 5708 Fernvale Ave

15- Filed 192 Robert F. Harrison, Registrar.

FC 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from about 6 mos. ago to Dec 3, 1924

that I last saw h. alive on Dec 3, 1924

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Heart disease (Chronic myocard.)

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs & symptoms

(Signed) A. F. Shemwell M. D.

Dec. 4, 1924 (Address) 2226 Madison Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Woodlawn Cem.	Dec. 6, 1924
20-UNDERTAKER, Harry W. Ehlen	ADDRESS 1944 W. North Av

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 92610

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92610

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4823 Parkhurst Ave. (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard V. Shelly

(Residence in Baltimore: No. 4823 Parkhurst Ave, St. 39 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Sept 8, 1885
(Month) (Day) (Year)

7-AGE. 39 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Shelly

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Tuttle

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Shelly

(Address) 4823 Parkhurst Ave

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

DEC 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1924
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov 24 1924, to Dec 1924, that I saw him alive on Dec 2 1924, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Oakley L. M. D.

Dec 3 1924 (Address) 223 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Catholic

DATE OF BURIAL. Dec 5, 1924

20-UNDERTAKER Martin Fahey Son

ADDRESS 1627 W Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Kyne)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92611 D 92611

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 W. Franklin St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kyne

(a) Residence No. 1122 W. Franklin St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 23-1875

7-AGE, 49 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Nurse 048

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Kyne

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Hynes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Catherine Kyne

(Address) 1122 W. Franklin St

15- Filed ..... Robert P. Harrison, Registrar.

EC 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/3/24

17- I HEREBY CERTIFY, That I attended deceased from June 14 1924 to Dec 3 1924, that I last saw h alive on Dec 2 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

Metastases to Lungs.

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion, Pulmonary oedema (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 1/24

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) J. W. Chesney M. D

1924 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
New Cathedral	12-5th 1924.
20-UNDERTAKER, H. C. Brauning & Son	ADDRESS 517 N. Schroeder St

Should be carefully supplied. Exact statement of OCCUPATION is very important. Cause of death must be properly classified. Statements should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

KEEP FLAT

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92612

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 205 Ridgewood Rd. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Jenkins Shriver

(a) Residence No. 205 Ridgewood Road St., 27 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 52 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? 52 yrs. 11 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Celestine Shriver

6-DATE OF BIRTH (month, day and year) Dec-25-1871

7-AGE, 52 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Member of firm

(b) General nature of industry, business, or establishment in which employed (or employer): Brilley & Shriver

(c) Name of employer: Self

9-BIRTHPLACE (city or town) (State or Country). Balto. Maryland

PARENTS.

10-NAME OF FATHER. Albert Shriver

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll Co. Maryland

12-MAIDEN NAME OF MOTHER. Annie Jenkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Maryland

14- (Informant) Mr. A. J. Shriver (Bro.)

(Address) University Club City

15- Filed DEC 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3 1924

17- I HEREBY CERTIFY, That I attended deceased from October 24 1924 to Dec 3 1924, that I last saw him alive on December 3, 1924, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

Symptoms (Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

Duration yrs. — mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What tests confirmed diagnosis? Clinical-Radioscopic

(Signed) Louis P. Hamburger, M. D.

Dec 4, 19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL, Dec 5, 1924.

UNDERTAKER. STEWART & BOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. Exact statement of OCC... in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

92613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 12 9 D 92613

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 201 N Montford ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Bessie Platt

(a) Residence No.... 201 N Montford ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~ Widow, or Divorced, (Write the word.)

5a-If married, widowed, or ~~divorced~~, HUSBAND of (or) WIFE of Charles

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 46 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Harrison

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Minnie Weiner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Wm Kessler

(Address) 1211 E Lanvale st

15- Filed DEC 5 - 1924 ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/4/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924, to Dec 4, 1924, that I last saw her alive on Dec 3, 1924, and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Tumbleson, M. D.

Dec 4 1924 (Address) 2013 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 12/7 1924

20-UNDERTAKER, Sol Levinson Bro — ADDRESS 1127 E Balto st

Burial Permit Issued

Should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92614

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D 92614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Walker ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bray

(a) RESIDENCE NO. 1615 Walker ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Bray

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 yr	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 170

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Adeline Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Addie E. Bray
(Address) 1615 Walker St.

15 Filed DEC 5 1924 ROBT. R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 2 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-30-1924, to 12-2-1924, that I last saw h alive on 12-2-1924, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis and oedema.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. H. Garges, M. D.

12-5-1924 (Address) 611 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	12-5 1924
20 UNDERTAKER	ADDRESS
Wm. Chas. H. Bailey	1421 Jefferson St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92615

CERTIFICATE OF DEATH.

99-00 ✓✓

D 92615

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Asquith Street Ashland Ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister M. Dircka Beck

(Residence in Baltimore: No. Convent of Notre Dame Asquith Street Ashland Ave St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, February 8, 1853, 1 (Month) (Day) (Year)

7-AGE, 75 yrs. 10 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Teacher 68
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baden Bavaria

PARENTS.

10-NAME OF FATHER, John Beck

11-BIRTHPLACE OF FATHER (State or Country), Bavaria

12-MAIDEN NAME OF MOTHER Josepha Fink

13-BIRTHPLACE OF MOTHER (State or Country), Bavaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sr. M. Hedwig .....

(Address) Convent of Notre Dame Asquith St. Ashland Ave

15- DEC 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3 d, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1923, to Dec 3 1924, that I saw h er alive on Dec 3 1924, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Bronchostasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. J. Kirby ..... M. D.

Dec 3, 1924 (Address) 1610 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md.	Dec 6, 1924
20-UNDERTAKER	ADDRESS
Frank A Fink	915 N. Gay St

N. B.—Every item of information should be carefully sought for, and given in full, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92616

CERTIFICATE OF DEATH.

1729 D 92616

REGISTERED NO.

1.-PLACE OF DEATH

CITY OF BALTIMORE. (No. 635 N. Central Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.-FULL NAME Edward Washington

(a) RESIDENCE NO. 635 N. Central Ave, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Rosa Washington

6 DATE OF BIRTH (month, day, and year) ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer M. K. Kirch

9 BIRTHPLACE (city or town) (State or country) Hanover Pa.

PARENTS

10 NAME OF FATHER Joseph Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover, Pa.

12 MAIDEN NAME OF MOTHER Maria Beuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover, Pa.

14 Informant Celia Graham

(Address) 635 N. Central Ave.

15 Filed DEC 5 - 1924 Robert R. Kraser, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 Dec. 1924

17 I HEREBY CERTIFY, That I attended deceased from √ November 1924, to 3 December 24.

that I last saw him alive on 2 " 1924

and that death occurred, on the date stated above, at √ a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

General

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia about 14 da.

(duration) — yrs. — mos.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Chemical.

(Signed) E. Mayfield Boyd, M. D.

4/12/1924 (Address) 635 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Osborn Cemetery

DATE OF BURIAL 12 7 1924

20 UNDERTAKER Mrs Chas L. Bailey

ADDRESS 1421 Jefferson

NOTE—AGE should be carefully supplied. Information should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92617

CERTIFICATE OF DEATH.

90 D 92617

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3101 Berkshire Road ST., 8 WARD)

2-FULL NAME Nicholas Parr

(a) RESIDENCE NO. 3101 Berkshire Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Magdalena Parr

6 DATE OF BIRTH (month, day, and year) February 2 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 016

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bettner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Agnes Parr

(Address) 3101 Berkshire Road

15

Filed DEC 5 - 1924 19 ROBT. R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 19 24

17

I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1923, to Dec 3, 1924, that I last saw him alive on Dec 3, 1924, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

about 5 yrs mos ds.
(duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm V. Watson, M. D.

Dec 4, 1924 (Address) 212 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 19 24
20 UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. The information required for CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Walnut ✓

D 92618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 126 D 92618

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Woman's Hospital St., 12 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lucille D Walat

511 Wyman Park apts

(a) Residence No..... St.,..... Ward Norfolk Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal.

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. S Walat.

6-DATE OF BIRTH (month, day and year) Dec 20 1895

7-AGE. 28 yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Richmond Va

PARENTS.

10-NAME OF FATHER. John Grady

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Lena May Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14-Informant..... Robt S Walat

(Address) Wyman Park Apts.

15-Filed DEC 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/4/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1924 to Dec 4 1924

that I last saw her alive on Dec 4 1924

and that death occurred, on the date stated above, at 3:12 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Cole Warfield Jr. M. D.

, 19 (Address) Woman Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Norfolk Va DATE OF BURIAL. Dec 5 1924

20-UNDERTAKER. Putnam Gore ADDRESS 1723 N. Lafayette

Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92619

CERTIFICATE OF DEATH.

REGISTERED NO. 14 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 Mosher St. (St.:) (Ward) 14

2-FULL NAME Sarah E. Hughes

(a) RESIDENCE. (No.) 637 Mosher St. (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Singleton R. Hughes.

6 DATE OF BIRTH (month, day, and year) 10-15-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Addison Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Debris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant S. B. Hughes

(Address) 1713 Druid Park Ave.

15 Filed DEC 5 - 1924, 19 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-1924

17 I HEREBY CERTIFY, That I attended deceased from 11-4-, 1924, to 12-2-, 1924, that I last saw h[illegible] alive on 12-2-1924 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Tonsilitis

(duration) yrs. 4 wks mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) George C Page, M. D.

, 19 (Address) 1720 W. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec 5 1924

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92620

CERTIFICATE OF DEATH.

75-002

D 92620

1-PLACE OF DEATH

City of BALTIMORE: (No. 1327 North Central ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Casey

(a) Residence No. 1327 North Central ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, ~~or Divorced~~ (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie E. Casey

6-DATE OF BIRTH (month, day and year) March 18, 1855

7-AGE. 69 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Lieut. Police 6

(b) General nature of industry, business, or establishment in which employed (or employer) Dept. of Balto

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Patrick J. Casey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ellen Curley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) James J. Casey Jr.

(Address) 1327 North Central ave

15- Filed DEC 5 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 1923 to Dec. 1 1924, that I last saw him alive on Dec 1 1924, and that death occurred, on the date stated above, at 11:15 P.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene - Heart

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Haggerty M. D.

Dec 3. 1924 (Address) 1216 N. Charles st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral

DATE OF BURIAL. December 5, 1924

20-UNDERTAKER. John Moran

ADDRESS 3000 E. Belto St.

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001
D 92621

REGISTERED NO. D 92621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Hrabel

(a) RESIDENCE NO 4th St & Edmondson Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 29/24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Less than 24	hrs		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jacob Hrabel

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Minnie ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hopkins Hospital
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 192 ROBERT R. KRAUTER Registrar

37 DEC 5 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Prematurity-6 1/2 mons gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. W. Holland, M. D.
(Coroner.)

12/3/24, 192 (Address) 508 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 4 1924

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92622

CERTIFICATE OF DEATH.

161-801 D 92622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Boy) Basch

(a) RESIDENCE NO Cypreess & Pennington Ave ST. Curtis Bay WARD Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Nov 30/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
8 hrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hopkins Hospital
(Address)

15 Filed DEC 5 - 1924 3820 ROBERT R. KRAUTER, Registrar
Assist Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(Autopsy at Hopkins Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. A. Gatewood, M. D.
(Coroner.)

12/3/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER Chief Inspector Health,

ADDRESS DEC 4 - 1924

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3317 E. Fait St., No. 41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr Buck Hornick.

(a) RESIDENCE NO 3317 E Fait ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Anna M. Honeck

6 DATE OF BIRTH (month, day, and year) June 4 1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Furriers Business
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer John Muller 046

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John Honeck

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna M. Honeck
(Address) 3317 E Baltimore St

15 Filed DEC 5 - 1924 Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) Contributory 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner.)
Dec 4, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 5 1924
20 UNDERTAKER Kurs C. Muller & Son	ADDRESS 2334 Jefferson

N. B.—WRITE PLAINLY, with ink or indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should supply all information. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92624

CERTIFICATE OF DEATH.

D 92624

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 109 So. Dallas St. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Raymond Smith

(a) Residence No. 109 So. Dallas St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colord

5-Single, Married, Widowed, or Divorced, (Write the word.) infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 1 1924

7-AGE. yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md. D

PARENTS

10-NAME OF FATHER. James Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). St. Mary's Co Md D

12-MAIDEN NAME OF MOTHER. Mary Sumerville

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md. D

14- (Informant). Casey Sumerville

(Address) 1571 E. Lumbard St.

15- DEC 5 - 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). December 3-24

17- I HEREBY CERTIFY, That I attended deceased from December 2., 1924 to December 3 1924 that I last saw him alive on December 3, 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. G. W. Bernard M. D

12-4. 1924 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn cemetery — DATE OF BURIAL. dec 5 1924

20-UNDERTAKER. Edward Bryan — ADDRESS 1631 Orleans St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92625

CERTIFICATE OF DEATH.

24 16-001

D 92625

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 Bloomsbury St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Peterson

(a) Residence No. 107 Bloomsbury St., Ward.....

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —Dec. 4. 1924

6-DATE OF BIRTH (month, day and year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 3 hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto., Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Max W. Peterson

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, May Johnson

13-BIRTHPLACE OF MOTHER (city or town)..... Atlantic City N.J.
(State or Country),

14-

(Informant)..... Max W. Peterson

(Address)..... 107 Bloomsbury St.

Filed DEC 5 - 1924 ROBT. J. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 4/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 4, 1924, that I last saw h. alive on Dec 4, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Exhaustion

.....(Duration)..... yrs..... mos..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) R. E. L. Campbell, M. D.

Dec 4, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Cross C.A.	Dec 5, 1924
20-UNDERTAKER,	**ADDRESS**
Margaret A. Lynch	1122 Light St.

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Riceman

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92626

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH 2735 Maryland ave. (If death occurred in a hospital or institution, give its NAME instead of street and number)

CITY OF BALTIMORE: (NO. ..... ST.: 12 WARD)

2-FULL NAME Belle Marietta Riceman

(a) RESIDENCE. NO. 2735 Maryland av. ST., ... WARD. Twelfth
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Frederick C. Riceman

6 DATE OF BIRTH (month, day, and year) Aug. 12 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ None

(c) Name of employer ✓ None

9 BIRTHPLACE (city or town) (State or country) Lynchburg, Va.

PARENTS

10 NAME OF FATHER James Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Delanoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Stanley H. Brady

(Address) 400 N. Bentley St. Apt. Baltimore

15 Filed DEC 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1924, to Dec 3, 1924, that I last saw her alive on Dec 3, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Watson, M. D.

Dec 4. 1924 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Dec 6 1924

20 UNDERTAKER Wilbur H Shriver ADDRESS 1018 Edmondson

mation should be carefully supplied. AGE should be stated in last birthday. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92627

CERTIFICATE OF DEATH.

D 92627

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 134 N. Washimgton St. ST., 6 WARD)

2-FULL NAME Rebecca Beckett

(a) RESIDENCE NO 134 N Washington St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Enos A. Beckett

6 DATE OF BIRTH (month, day, and year) March 16/1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	83	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Caleb B Blizzard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Caleb E. Beckett (Address) 3345 18th St. N.W. Washington D.C.

15 Filed DEC 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Sclerosis (Duration) yrs. mos. ds.

(Signed) J. S. H. Porter (Coroner.) M. D.

12/6/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.... yrs., ... mos., ... ds. In the State.... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec. 6, 192 4

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

mation should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor. 2-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92628

CERTIFICATE OF DEATH.

D 92628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Sharp St. ST., 22 WARD)

2-FULL NAME Michael King.

(a) RESIDENCE NO. 818 S. Sharp St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer. 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Ferdinand Fruhling.
(Address) 818 S. Sharp St.

15 Filed 192 ROBERT R. KRAUTER. Registrar

DEC 5 - 1924 TO MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1st, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of the throat.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Arthur Reinhardt, M. D. (Coroner.)

Dec, 3rd, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL. DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health, ADDRESS DEC 5 - 1924

Dep. Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92629

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 N Paca ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Lee

(a) RESIDENCE. No. 122 N. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mongolian White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 31 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Lee Omong

11 BIRTHPLACE OF FATHER (city or town) (State or country): China

12 MAIDEN NAME OF MOTHER: Rose Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): China

14 Informant: Lee Omong

(Address): 122 N. Paca St

15 DEC 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1924, to Dec 3, 1924, that I last saw h[illegible] alive on Dec. 3, 1924, and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Reynolds M.D.

12-4 1924 (Address) 1531 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 5 1924
20 UNDERTAKER	ADDRESS
John O Mulcahey	1201 W Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92630

D 92630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Home of Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther B Dilch

(a) Residence No. Mt Hope Retreat St., 25 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June (?) 1854

7-AGE, 70 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Franklin Co (State or Country). Pa

PARENTS.

10-NAME OF FATHER, John Dilch

11-BIRTHPLACE OF FATHER (city or town) Franklin Co (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) Franklin Co (State or Country), Pa

11- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Retreat Baltimore

15- Filed DEC 5 1924 Robert R. Reuter Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1924 to Dec 4 1924 that I last saw h.. alive on Dec 4 1924 and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

Abt (Duration) One yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Mal Dep. Psychosis

Abt (Duration) 1 yrs. 3 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 6 1924

20-UNDERTAKER, John Mitchell ADDRESS 120 W Lafayette

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 92631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

574-001

D 92631

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2142 Walbrook Avenue St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Coleman

(Residence in Baltimore: No. 2142 Walbrook Avenue St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. January 6th 1866 (Month) (Day) (Year)

7-AGE. 58 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Goodys Oyster Packing House

9-BIRTHPLACE. (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. William H. Coleman

11-BIRTHPLACE OF FATHER. (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Louise Barringer

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Alice Coleman

(Address) 2142 Walbrook Ave.

15- ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2nd 192 4
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, Autopsy, or Inquiry.) thereon and from the evidence obtained by said inquest, an inquiry (Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

12-3 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Dec 5 1924

20-UNDERTAKER. Joseph B. Cook ADDRESS. 1003 N. Bond St.

N. B.—Every item of information should be carefully supplied. Age must be given. If it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92632 X 101-001 D 92632

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 4157 Rosedale Ave ST., 21 WARD) Fardenville

2-FULL NAME Frances L Parsons

(a) RESIDENCE NO. 4157 Rosedale Ave ST., WARD Bear Jersey

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Parsons

6 DATE OF BIRTH (month, day, and year) Dec 7, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Dove Sky Light Co

(c) Name of employer New York

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER George Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emily Burkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Frances Parsons

(Address) 81 Chestnut Ave Delaware, N J

15 DEC 5 - 1924 ROBERT R. KRAMES Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1924, to Dec 4th, 1924, that I last saw h[illegible] alive on Dec 4th, 1924, and that death occurred, on the date stated above, at 1145P m.

THE CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 7 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas R Hostetter, M. D.

, 19 (Address) 520 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Amboy NJ	Dec 6, 1924

20 UNDERTAKER Helen Cook ADDRESS 1 E Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should fill mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92633

CERTIFICATE OF DEATH.

67-006

1-PLACE OF DEATH Church Home & Infirmary

Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Chase Hinks

(a) Residence No. Church Home & Infirmary St., Ward Frederick Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Hinks

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, About 70 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), St Louis Mo

PARENTS.

10-NAME OF FATHER Robt E Chase

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Janet Chase

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14-Informant Mrs Chas E Wolfe

(Address) 2015, 14th St NW Washington DC

15-FILED DEC 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1924 to Dec 5 1924

that I last saw h.. alive on Dec 5 1924

and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Henry V P Wilson M. D

, 19 (Address) Church Home & Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Frederick Md — DATE OF BURIAL, Dec 8th 1924

20-UNDERTAKER, C C Cary — ADDRESS Frederick Md.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21 M&T 1500 Bks.

W. Innes 720 W. Fayette St

D 92634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 92634

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 620 N. Hilton ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude F. Ritter

(a) RESIDENCE NO. 620 N. Hilton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should be mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. H. Ritter

6 DATE OF BIRTH (month, day, and year): Jan 3rd 1870

7 AGE	Years	Months	Days	If LESS than 1 day, . hrs or .... min.
	54	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: 037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Hipsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Fetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Geo. H. Ritter

(Address): 620 N. Hilton St

15 Filed DEC 5 - 1924 [redacted] S. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1924, to Dec 4, 1924, that I last saw h[illegible] alive on Dec 3, 1924, and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver & brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis from Carcinoma of breast

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Jones, M. D.

1925, 1924 (Address) 720 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 6 1924

20 UNDERTAKER: H. D. [redacted]pfield — ADDRESS: 1850 W. Baltimore St

D 92635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92635

CERTIFICATE OF DEATH

REGISTERED No. C 9

1 PLACE OF DEATH 532
CITY OF BALTIMORE (No. 532 East 22nd Street, St.; 9 Ward)
(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs. Mary Ireton
(Residence in Baltimore: No. 532 East 22nd Street St.; 48 yrs. ---- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6 DATE OF BIRTH: July 7th, (Month) (Day), 1848 (Year)

7 AGE: 76 years yrs. 5 mos. ----- ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Peter Sheridan
11 BIRTHPLACE OF FATHER (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Ann McCabe
13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev. Peter L. Ireton
(Address) 532 East 22nd St

15 Robert P. Harrison,
Filed ....., 191 ..... REGISTRAR
Burial Permit Clerk

EC 5 - 1924

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 5th (Month) (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 25th. 1917 to Dec. 5th, 1924, that I saw her alive on December 5th 1924, and that death occurred, on the date stated above, at 1.30 a m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 8 yrs. --- mos. --- ds

Contributory (SECONDARY) ..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Thomas L. Shearer M. D.
Dec. 6th 1924 (Address) 905 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral
DATE OF BURIAL: Dec. 6, 1924
20 UNDERTAKER: Charles Sacker Sons
ADDRESS: 17 W. Mount ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92636

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 743 Linnard St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelia M Norfolk

(a) Residence No. 743 Linnard St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Vinderville Norfolk

6-DATE OF BIRTH (month, day and year) Dec 29th 1848

7-AGE, 75 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ellicott City Md

PARENTS.

10-NAME OF FATHER Lloyd Gorsuch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Beacham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Chas Wainker

(Address) 743 Linnard St

15- Filed DEC 5 1924 192 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 4th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1924, to Dec 4 1924, that I last saw h alive on Dec 3 1924 and that death occurred, on the date stated above, at 615 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Abdominal Sx

(Signed) J. M. Lamperin M. D.

Dec 6 1924 (Address) 426 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, 12/6/24 19....

20-UNDERTAKER, Geo. Weber & Son — ADDRESS 2503 Edmondson ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92637

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2919 Penna ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Finlay

(a) Residence No. 2919 Penna ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wm B. Finlay

6-DATE OF BIRTH (month, day and year) Mar 11 1843

7-AGE, 81 yrs. 8 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Isaac Shannon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER Sarah Stone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Geo. A. Finlay

(Address) 2919 Penna ave

15- Filed DEC 5 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 4 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 14, 1924, to Dec 4, 1924, that I last saw h[illegible] alive on Dec 4, 1924, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombus,
Mitral regurgitation
cardiac dilatation, hemiplegia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(Duration) yrs. mos. 1/2 ds.

18-Where was disease contracted if not at place of death? 2918 Penna Ave

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Findings

(Signed) D. P. Slaskie M. D.

, 19 (Address) 336 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL, 19
Druid Ridge	12/6/24
20-UNDERTAKER	ADDRESS
Chas. Weber Son	2503 Edmondson ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92638

CERTIFICATE OF DEATH.

129 D 92638

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Church St. Curtis Bay ST. 25 WARD)

2-FULL NAME John Swierozeroski.

(a) RESIDENCE NO. 26 Church St. Curtis Bay ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 14 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charles Patrick.
(Address) 26 Church St. Curtis Bay.

15 Filed DEC 5 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 4, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

Dec, 5, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Curtis Bay) DATE OF BURIAL Nov. 6, 1924

20 UNDERTAKER William Fiszkowski in Y.C. ADDRESS 111 S Eastern

NOTE—WRITE PLAINLY. Ink should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92639

CERTIFICATE OF DEATH.

X202

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., ? WARD)

2-FULL NAME Homer Winters

(a) RESIDENCE NO Ripley, W.Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 24 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 3 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) W. Va.

PARENTS

10 NAME OF FATHER Arthur L. Winters

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) W.Va.

12 MAIDEN NAME OF MOTHER Lena Reynolds

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) W.Va.

14 Informant Johns Hopkins Hospital
(Address)

15 Filed ..... 192 Robert P. Harrison Registrar

DEC 5 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Cervical Spine
(Accidental-occurred while playing foot ball-operation at Hopkins Nov 11/24) (duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Pyelonephritis (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Patten, M. D.
(Coroner.)

12/5/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ripley W. Va. DATE OF BURIAL Dec. 5 1924

20 UNDERTAKER Wm. L. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH must be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92640

CERTIFICATE OF DEATH.

D 92640

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N Carrollton Ave ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Francis Hughes

(a) RESIDENCE NO. 722 N Carrollton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Oct 27 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm J Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary J Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Lillian E Bangen

(Address) 722 N Carrollton Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

DEC 5 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/24 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 19 23 to Dec 5 24 19 ,

that I last saw h alive on Dec 4 1924 ,

and that death occurred, on the date stated above, at 7 am m.

The CAUSE OF DEATH* was as follows:

Chronic Prodigious Endocard-
(R Lenuden)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H C Hurst M. D.

19 (Address) 1429 N Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	12-8 1924
20 UNDERTAKER Robert Brooks & Son	ADDRESS Calhoun Hollins

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92641

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 5 WARD)

2-FULL NAME Mrs Eva Rainey

(a) RESIDENCE No. 1437 Eastern Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Richard Rainey

6 DATE OF BIRTH (month, day, and year) 4/23/1890

7 AGE	Years	Months	Days	If LESS than 1 day ~~hrs.~~ or ~~min.~~
	34	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md U. S.

PARENTS

10 NAME OF FATHER Frank Marlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Richard Rainey (Address) 1437 Eastern Ave

15 Filed DEC 5 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/9, 1924, to 12/3, 1924.

that I last saw h[illegible] alive on 12/3, 1924

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

1. Suppurative Pleurisy.
2. Myocardial failure

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cholecystitis & Cholelithiasis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 11/4/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hurley Sanders, M. D.

, 19 (Address) 7 Elmora Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 12/6/24

20 UNDERTAKER Geo. J. Ruth & Son — ADDRESS 3[illegible] Harford Ave

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S STATE mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92642

1,23878
92642

CERTIFICATE OF DEATH.

+ 100

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Berkeley Ward

(a) RESIDENCE NO. E. 315 Rockwell Terrace WARD Fredrck, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs P. W. Ward

6 DATE OF BIRTH (month, day, and year) Aug 8, 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Grace Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 5 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1924, to Dec 5, 1924, that I last saw him alive on Dec 5, 1924, and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Brain Abscess (Pyogenic)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Frederick Md

Did an operation precede death? Yes Date of Aug 12 '24

Was there an autopsy? Yes

What test confirmed diagnosis? Pathol

(Signed) Rockwell Wilson M. D.

19 (Address) Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md — DATE OF BURIAL Dec 8 1924

20 UNDERTAKER C C Conly — ADDRESS Frederick Md.

FC5 - 1924

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. AGE should be stated EXACTLY. INFORMATION should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92643

CERTIFICATE OF DEATH.

5 197

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital. ST., WARD)

2-FULL NAME John Fortune.

(a) RESIDENCE NO. 100 N.Front St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) December 4, 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER John Fortune.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Philpott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Thomas J.Fortune.(brother).
(Address) 3029 Belmont Ave.

15 Filed DEC 6 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.4th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia result of a pistol shot wound in the chest. Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt (Coroner), M. D.

Dec. 6, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Shot at 100 N. Front St. November 26th, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Dec 6 1924

20 UNDERTAKER Wm Cook ADDRESS 652 E Pratt

H.—WRITE PLAINLY, with unfading ink. All questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92644

D 92644

CERTIFICATE OF DEATH.

Registered No. 164

1-PLACE OF DEATH

City of BALTIMORE (No. 16 S. Highland Ave 26 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Herman

(a) Residence No. 16 S. Highland Ave 26 St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 24 1836

7-AGE. 86 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs Emma E. Posey

(Address) 16 S. Highland Ave

15- Filed 192 Robert P. Harrison, Registrar.

DEC 6 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1924 to Dec 3 1924

that I last saw h.. alive on Dec 3 1924

and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D

, 192 (Address) 15 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Pauls Cemetery	Dec. 6, 1924
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	170 West H

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92645

CERTIFICATE OF DEATH.

74 D 92645

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2220 Eastern Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Krich

(a) Residence No. 2220 Eastern Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis Krich

6-DATE OF BIRTH (month, day and year) Feb. 21, 1849

7-AGE. 75 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Meyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Caroline Rettner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Caroline Damm

(Address) 2216 Eastern Ave

15- Filed Dec 6 1924 Robert E. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 3/1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1924 to Dec 3 1924

that I last saw her alive on Dec 3 1924

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Kerr M. D.

12/5/24 (Address) 405 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel Cemetery

DATE OF BURIAL. Dec 7 1924

20-UNDERTAKER. H. Sander Sons

ADDRESS 1710 E. Lexington St.

DEC 6 1924

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY as required. Exact statement of OCCUPATION is very important, in plain terms, so that it may be properly classified. • instructions on back of certificates.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92646

D 92646

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH
City of BALTIMORE: (No. Erdman ave na Harford Rd St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME D. Walker Richmond

(a) Residence No. Erdman ave nr Harford Rd St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary M Richmond

6-DATE OF BIRTH (month, day and year) Oct 30 1861

7-AGE. 63 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Samuel Richmond

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Elizabeth Bell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant). Mary M Richmond
(Address) Erdman ave

15- Filed ..... 192 ..... Registrar.

26 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 5 1924

17- I HEREBY CERTIFY, That I attended deceased from November 25 1924 to December 5 1924, that I last saw h~~e~~r alive on December 4 1924, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:
Valvular disease of the Heart

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) valvular disease of Heart

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Lawrence Whitbeck, M. D.

1924 (Address) 1600 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ RE~~MOVAL~~. Greenmount Cemetery DATE OF BURIAL, Dec 7th 1924

20-UNDERTAKER. George Schilling & Sons ADDRESS 1116 E Monument st

should be carefully supplied. Any illegible or incomplete statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. Exact

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92647

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 N. Monroe St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Storney

(a) Residence No. 17 N Monroe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James T Storey

6-DATE OF BIRTH (month, day and year) March 22 1849

7-AGE. 75 yrs. 8 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas Storney

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jane Sheldon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant) James Storney Jr

(Address) 17 N Monroe St

15- Filed DEC 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/4/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1924, to ....., 19.....

that I last saw him alive on Dec 4th 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Old age

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Hoff M. D.

, 19 (Address) 1843 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. Dec 6 1924

UNDERTAKER. Wm J Fuchs Sons

ADDRESS North Ave

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92648 D 92648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 4634 York Road St., 27 57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Burt Krager

(a) Residence No. 4634 York Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Albert Krager

6-DATE OF BIRTH (month, day and year) July 8, 1856

7-AGE. 68 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.
10-NAME OF FATHER, James Crowley
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Phila Pa
12-MAIDEN NAME OF MOTHER, Elizabeth Briggs
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Phila Pa

14- (Informant) Mrs. Wm. Whistle
(Address) 4634 York Road

15- Filed DEC 6 - 1924 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 3d 1924 to Dec. 5th 1924
that I last saw her alive on Dec. 4th 1924
and that death occurred, on the date stated above, at 6.25 A.M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. Titus M.D., M. D.
12-5-, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Dec 8 1924
20-UNDERTAKER.	ADDRESS
Wm Pickues Sons	North Ave

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92649

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE (No. 1706 W Lafayette ave 16 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Andrew Wheeler

(a) Residence No. 1706 W Lafayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Bertha L. Wheeler

6-DATE OF BIRTH (month, day and year) March 5-1854

7-AGE. 70 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coffee

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer Self

9-BIRTHPLACE (city or town)..... (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas Wheeler

11-BIRTHPLACE OF FATHER (city or town) Annapolis (State or Country), Md

12-MAIDEN NAME OF MOTHER, Maria Revors

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Virginia

14-(Informant) Bertha L. Wheeler

(Address) 1706 W Lafayette Ave

15-Filed DEC 6 - 1924 19?

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 4-24

17-I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1923 to Dec. 4, 1924

that I last saw him alive on Dec. 2, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Austin F. Robinson M. D.

12/5, 1924 (Address) 130 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, Dec 6 1924

20-UNDERTAKER. H. J. Feldner & Sons

ADDRESS Northern

d. Exact statement of OCCUPATION is very important. Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92650

CERTIFICATE OF DEATH.

X 129

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Lafayette & Dayson ST., 70 WARD)

2-FULL NAME Mrs. Ferdinand C Dugan

(a) RESIDENCE NO. Catonsville, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melanie Borne Dugan

6 DATE OF BIRTH (month, day, and year) Sept 18th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER C. Dugan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Harriet Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Mr Harry C Dugan 907 St Paul St

15 Filed DEC 6 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12th, 1924, to Dec. 5th, 1924.

that I last saw him alive on Dec. 5th, 1924;

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute exacerbation of chronic pancreatic hypertrophic nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Laboratory tests

(Signed) Hugh Powell, M. D.

12/5/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Dec 8 1924

20 UNDERTAKER Henry M Jenkins & Son Co

ADDRESS Edmondson Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. See Instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92651 179 D 92651

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Dave Woodruff

(a) RESIDENCE NO 17 Dobbins Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Don't Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Don't Know

9 BIRTHPLACE (city or town) ( )
(State or country)

PARENTS

10 NAME OF FATHER ( )

11 BIRTHPLACE OF FATHER (city or town) ( )
(State or country)

12 MAIDEN NAME OF MOTHER ( )

13 BIRTHPLACE OF MOTHER (city or town) ( )
(State or country)

14 Informant .....
(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

DEC 6 - 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~Inquest, au-~~ his death ~~topsy or inquiry.~~) on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on body

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Clothing caught from stove

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Jenkins, M. D.
(Coroner.)

12-5, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mns.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Dec 6 1924

20 UNDERTAKER A. Jones ADDRESS 1165 Gilmor St

Cor.—1-12-23—M&T—100 Bks.

D 92652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92652

CERTIFICATE OF DEATH.

167

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 W. Pratt ST. 19 WARD)

2-FULL NAME Mrs Mollie E. Condon

(a) RESIDENCE No 1520 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Francis H. Condon

6 DATE OF BIRTH (month, day, and year): Apr 26 1870

7 AGE — Years: 54 — Months: 7 — Days: 8 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Edward Willey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Francis H Condon
(Address) 1520 W Pratt St

15 Filed DEC 6 - 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Dec 5 1924 (Address) Courthouse

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 6th 1924

20 UNDERTAKER: A. Jones — ADDRESS: 1121 Gilmor St

mation should be carefully supplied. Exact statement of occ... that it may be properly classified.
CAUSE OF DEATH in plain terms, so that i...
TION is very important. See instructions on back of certificate.

Spec- 12-23-21- E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92653

CERTIFICATE OF DEATH.

D 92653

1-PLACE OF DEATH Church Home and Infirmary 6

City of BALTIMORE: (No. Broadway & Fairmount St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Mahla

(a) Residence No. 526 North Decker Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha M. Mahla

6-DATE OF BIRTH (month, day and year) May 25/85

7-AGE. 39 yrs. 6 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Asst. Credit Manager

(b) General nature of Industry, business, or establishment in which employed (or employer) Hecht + Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Casper Mahla

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Christina Voelker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Bertha M. Mahla

(Address) 526 N. Decker Ave

15- Filed 19 Robert P. Harrison, Registrar.

DEC 6 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1924, to Dec. 5, 1924, that I last saw him alive on Dec. 5, 1924, and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) — yrs. — mos. ? ds.

18-Where was disease contracted if not at place of death? 526 N Decker Ave

Did an operation precede death? Yes Date of Nov. 21, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm. C. Rice M. D

, 19 (Address) Church Home & Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oak Lawn — DATE OF BURIAL, Dec 8, 1924

20-UNDERTAKER, Philip Herwig — ADDRESS 2016 Orleans St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92654

CERTIFICATE OF DEATH.

89 D 92654

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 326 S. Robinson St St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Pfeifer

(a) Residence No. 326 S. Robinson St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elva F. Pfeifer

6-DATE OF BIRTH (month, day and year) June 24 1877

7-AGE. 47 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Police

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Falls City

PARENTS.

10-NAME OF FATHER, Henry Pfeifer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mrs Elva F. Pfeifer

(Address) 328 S. Robinson St

15- Filed DEC 6 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 2/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1924 to Dec 2 1924

that I last saw h.. alive on Dec 2 1924

and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Degen

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Death

(Signed) Standard McCalmont M. D

, 19 (Address) 1699 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Dec 6th 1924

20-UNDERTAKER Philip Stenig ADDRESS 2116 Orleans St

Exact statement of OCCUPATION is very important and should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92655

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisha Gross

(a) RESIDENCE NO. 208 N. Strieker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE: Years 27; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Johnson

(c) Name of employer

821

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Gross

(Address) 208 N. Strieker

15 DEC 6 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5- 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-29- 1924, to 12-1- 1924,

that I last saw h alive on 12-5- 1924

and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, (Bilateral)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. F. Parr, M. D.

12/5/ 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Md.

DATE OF BURIAL 12-7-24

20 UNDERTAKER Edmund Easter

ADDRESS 916 Pa ave

C. B.—WRITE PLAINLY, with pen and ink, and supplied. AGE should be carefully supplied. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92656

D 92656

CERTIFICATE OF DEATH

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Carey St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Gibson

(a) RESIDENCE NO. 916 Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer none

9 BIRTHPLACE (city or town) West River

(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Gibson

11 BIRTHPLACE OF FATHER (city or town) South River

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Boston

13 BIRTHPLACE OF MOTHER (city or town) West River

(State or country) Maryland

14 Informant Walter Thelane

(Address) 916 Carey St.

15 Filed ... 19 ... Registrar

Burial Permit Clerk.

DEC 6 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4- 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-24 1924 to 11-27 1924.

that I last saw her alive on 11-27 1924.

and that death occurred, on the date stated above, at 12:5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthysis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Low resistance to tubercles

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of July 1923

Was there an autopsy? No

What test confirmed diagnosis? examination

(Signed) Frank F Saunders M. D.

19 (Address) 1130 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-7-24

ADDRESS 916

20 UNDERTAKER Dan'l Carson Co

N. B.—WHITE PAPER, when supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92657

CERTIFICATE OF DEATH.

160 92657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 110 N. Carroll (Street) Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Glascoe

(a) RESIDENCE NO. 110 N. Carrollton Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 9th 1924

7 AGE: Years — | Months: 3 | Days: 23 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Glascoe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Emma Glascoe
(Address) 110 N. Carrollton Ave

15 Filed DEC 6 1924, 192

Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Autopsy and Inquest find that said deceased came to death as stated (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition,

(duration) Since Birth

CONTRIBUTORY (Secondary) 8 mos Child

(duration) yrs. mos. ds.

(Signed) Wm. Bue Horton, M. D.
(Coroner.)

Dec 3, 1924 (Address) Curtis Bay Md

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-6-1924
UNDERTAKER: Wm J Easton	ADDRESS 916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92658

CERTIFICATE OF DEATH.

D 92658

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1910 W Pratt ST. 18 WARD)

2-FULL NAME George E. McCubbin.

(a) RESIDENCE No. 1910 W. Pratt St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William McCubbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Louisa Clark.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bal.

14 Informant (Address) Mr George McCubbin. 1110 W Pratt St.

15 [illegible] 6 - 1924 , 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/ 1924

17

I HEREBY CERTIFY, That I attended deceased from 12/3/ 1924, to 12/5/ 1924,

that I last saw him alive on 12/4/ 1924

and that death occurred, on the date stated above, at 3 1. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Malignant)

(duration) from Nov 28 (Hosp) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic Hosp Path (Lumbar)

(Signed) Bernard A. Cohn, M. D.

12/5, 1924 (Address) 910 W Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Dec, 1924
20 UNDERTAKER	ADDRESS
Geo F Cowan & Son	901 Hollins St.
Geo F Cowan	

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See Instructions on back of certificates.

Spec—12-23-24—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Women Home St., 19 Ward)

Registered No. 92659

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ellen Neville

(a) Residence No. 1400 W Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 22/1837

7-AGE. 87 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Dublin Harford Co

PARENTS.

10-NAME OF FATHER. John Neville

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Harford Co

12-MAIDEN NAME OF MOTHER. Elizabeth Bateman

13-BIRTHPLACE OF MOTHER (city or town) Darlington
(State or Country). Harford Co Md

14- (Informant) Ella F Jones
(Address) 1400 W Lexington St

15- Filed DEC 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 5 24

17- I HEREBY CERTIFY, That I attended deceased from June 19 24, to Dec 5 19 24

that I last saw h.....alive on Dec 5 19 24

and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Dec, 19 (Address) 939 W Fay Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Dec 8, 1924
20-UNDERTAKER. George J Smith	ADDRESS 1532 Hollins St

Should be written plainly, in ink, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Wilkens ave & Whittemore ave (WARD) 20

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter M. Bradley

(a) RESIDENCE NO. Wilkens ave & Whittemore ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1st 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	—	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 020
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Rowena V. LeCompte
(Address) 704 N. Arlington ave

15 Filed DEC 6 - 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest autopsy or inquiry.) thereon and from the evidence obtained by said (Autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John B. Horton, M. D.
(Coroner.)

Dec 5 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 8 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 92661 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 119 Bloomberg St., 24 Ward) Registered No. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Damm

(a) Residence No. 119 Bloomberg St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widow, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Ms.

6-DATE OF BIRTH (month, day and year) Jan 24 1857

7-AGE 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stakeman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS

10-NAME OF FATHER. John Damm

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Benjamin Damm

(Address) 119 Bloomberg

15- Filed Dec 9 1924 Robert P. Harrison, Registrar.

C6 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1924 to Dec 5 1924 that I last saw him alive on Dec 5 1924 and that death occurred, on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia, MW

Coma

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Possibly Nephritis.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hamm M. D

19 (Address) 1215 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Federal DATE OF BURIAL. Dec 9 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 E Lee

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

92662

HEALTH DEPARTMENT—CITY OF BALTIMORE

92662

CERTIFICATE OF DEATH.

100-00 D 92662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1841 S. Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lorraine Sperl

(a) RESIDENCE No 1841 S. Hanover ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	—	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Herman J. Sperl

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Birdie B. Hetzel

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Herman J. Sperl
(Address) 1841 S. Hanover St.

15 Robert T. Harrison,
Registrar

C6 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Dec 5, 1924

that I last saw h~~e~~r alive on Dec 5, 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia
(Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. Campbell M. D.

Dec 5, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Cemetery	Dec. 8 1924
20 UNDERTAKER Fredk Loeffler & Sons	ADDRESS Frederick

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92663

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 S Sharp St., 22 31 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carrie Thomas

(a) Residence No. 810 S Sharp St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Clk

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6-DATE OF BIRTH (month, day and year) Dec 12 1908

7-AGE, 15 yrs. 11 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS:

10-NAME OF FATHER, Henson Thomas

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Marjorie Harris

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) Marjorie Thomas

(Address) 810 S Sharp St

15- Robert P. Harrison,

Filed DEC 6 1924 192.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/4/24

17- I HEREBY CERTIFY, That I attended deceased from 11/1/24, 19..., to 12/4/24, 19..., that I last saw h... alive on 12/4/24, 19..., and that death occurred, on the date stated above, at 1025 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

about (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)* Chronic Recurrent Bronchitis about 1 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Xrays.

(Signed) Thomas D. Wolfe, M. D.

12/5/24, 19.. (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn DATE OF BURIAL, 12-7, 19..

20-UNDERTAKER. John H. Troadec ADDRESS 1057 Hanover

Exact statement of OCCUPATION is very important. Please see in plain terms, so that it may be properly classified. instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92664

CERTIFICATE OF DEATH.

12 9 D 92664

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 Myrtle Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Pressbury

(a) Residence No. 1318 Myrtle Av St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1884

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), md

PARENTS.

10-NAME OF FATHER, Geo Colclick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), md

12-MAIDEN NAME OF MOTHER, Elizabeth Bishop

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md

14- (Informant) Lloyd Pressbury

(Address) 1318 Myrtle Ave

15- Filed 192.... Registrar.

Robert F. Harrison, Burial Permit Clerk

C6 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/6/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 2, 19.24 to Dec 6, 19.24

that I last saw h. Ex alive on Dec 5 19.24

and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(Duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H. S. McCaul M. D.

12/6, 1924 (Address) 1005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenlawn Dec 8, 19.24

20-UNDERTAKER. John H. Toadvine md ADDRESS 1027 N. Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Eks.

D 92665

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 D 92665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 779 St Peter St 21 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert A. Lang

(a) Residence No. 779 St Peter St

(Usual place of abode) St.,.....Ward.....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 16, 1924

7-AGE, ...yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Charles A. Lang

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Alice Bushong

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Charles A. Lang

(Address) 779 St Peter St

15- Filed.....1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1924 to Dec 5, 1924

that I last saw him alive on Dec 4, 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Osteo-myelitis left thigh and right forearm

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 30/24

Was there an autopsy? No Removal of Thigh

What test confirmed diagnosis?

(Signed) H. Lang Boyd M. D.

, 19 (Address) 607 Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, Dec 6 19 24

20-UNDERTAKER. Harry H. Witzke

ADDRESS 1531 Lombard

C6 - 1924

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92666

CERTIFICATE OF DEATH.

12185

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 203 West 27th St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary Jane Neidert

(a) Residence No. 203 West 27th St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Neidert

6-DATE OF BIRTH (month, day and year) July 14 1835

If LESS than 1 day, ...hrs. or ....min.?

7-AGE 89 yrs. 4 mos. 21 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (City or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Chas. Lawton

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Hagerstown Md

12-MAIDEN NAME OF MOTHER. Elizabeth Brazer

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Harford Co Md

14- (Informant) Mrs Margaret Wade

(Address 203 West 27 st

15- Filed DEC 6 1924 192.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5/924

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 1924 to Dec 5 1924

that I last saw h— alive on Dec 4— 19.....

and that death occurred, on the date stated above, at 2.45 p m.

The CAUSE OF DEATH* was as follows:

Confinement in bed

as result of surgery & Cancer

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Condition

(Signed) R C Norment M. D.

12-1- 1924 (Address) 5547 Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill

DATE OF BURIAL. Dec 8 1924

20-UNDERTAKER. John F. Denny

ADDRESS 715 Light St

WRITE PLAINLY, with INK. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Please see should be carefully supplied. AGE should be properly classified. in plain terms, so that it may be instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks. MARY BROWN

D 92667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 Cumberland St., 15 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Brown

(a) Residence No. 705 Cumberland St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Brown

6-DATE OF BIRTH (month, day and year) Mar 10 1880

7-AGE.	If LESS than 1 day,
44 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)..... 170

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va.
(State or Country),

PARENTS.

10-NAME OF FATHER, Jasper Roy

11-BIRTHPLACE OF FATHER (city or town)..... Va.
(State or Country),

12-MAIDEN NAME OF MOTHER, N.K. known

13-BIRTHPLACE OF MOTHER (city or town)..... N.K. known
(State or Country),

14-

(Informant)..... Robert Brown

(Address)..... 705 Cumberland St.

15-

DEC 7 - 1924 ROBERT R. KRAUTER,
Registrar.

Assist. Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924, to Dec 5, 1924, that I last saw h.. alive on Dec 5, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) E. Wallace Freel M. D.

Dec 6, 1924 (Address) 1928 Pennsylvania Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	12-8-1924
20-UNDERTAKER.	ADDRESS
Daniel Easter	916 Pa Ave

should be carefully supplied. Age should be stated EXACTLY. Information of OCCUPATION is very important. See that it is correctly classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92668

90

CERTIFICATE OF DEATH.

D 92668

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 895. Park ave ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary — Corbett

(a) RESIDENCE. NO. 895 Park ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. ~~How long in U. S., if of foreign birth?~~ yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James A. Corbett

6 DATE OF BIRTH (month, day, and year) (1881)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	Don't know		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress — 41

(b) General nature of industry, business, or establishment in which employed (or employer) Washing & Ironing

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Savannah — Georgia

PARENTS

10 NAME OF FATHER William Moye.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savanah Georgia

12 MAIDEN NAME OF MOTHER Julia Jones —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Savanah Georgia

14 Informant Robert Simmons - Brother
(Address) 1202 Mc Culloh

15 Filed DEC 7 - 1924 19 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19th —, 1924, to Dec. 5th, 1924, that I last saw her alive on Dec. 5th, 1924, and that death occurred, on the date stated above, at 2 a — m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

about — (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dropsy — Nephritis

about (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at place of Death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? General Examination

(Signed) Samuel A Davis, M. D.

, 19 (Address) 937 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ave — DATE OF BURIAL 12-8-24

20 UNDERTAKER D. M. Deacon — ADDRESS 916 Park ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Stoc—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92669 (stamped) 90 D 92669 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1052 Lemmon St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Goldberg

(a) Residence No. 1052 Lemmon ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Goldberg

6-DATE OF BIRTH (month, day and year) Unknown 1878

7-AGE. 46 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Russia

PARENTS.

10-NAME OF FATHER, Joseph Lebesky

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Russia

12-MAIDEN NAME OF MOTHER Kate —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14- (Informant) Aaron Goldberg

(Address) 105 Lemmon ave

15- Filed DEC 7 1924 ROBERT R. KRAUTER, Registrar. Social Service Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/5/24

17- I HEREBY CERTIFY, That I attended deceased from 12-2 1924 to 12-5 1924 that I last saw h[illegible] alive on 12-5 1924 and that death occurred, on the date stated above, at 10 P. m. The CAUSE OF DEATH* was as follows:

Mitral Stenosis chronic val-
vular insufficiency (Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Coronary artery rupture
Angina pectoris (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ordinary tests

(Signed) S. Posen M. D.

12-6. 1924 (Address) 2026 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Henry Southern DATE OF BURIAL. 12/7 1924

20-UNDERTAKER. Jack Levin ADDRESS 1409 Eagle St

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92670

CERTIFICATE OF DEATH.

188-003

188 D 92670

REGISTERED NO.

1-PLACE OF DEATH Pronounced Dead at

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Silverman

(a) RESIDENCE NO. 1814 E Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Silverman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoe Steers 186
(b) General nature of industry, business, or establishment in which employed (or employer) Jobber Corset
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Chas Fish
(Address) 1914 E Pratt St

15 Filed , 192 HELEN S. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base of Skull
automobile accident
while delivering
papers (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Gaubert, M. D.
(Coroner)

Dec 6, 192 4 (Address) 1002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph

DATE OF BURIAL 12/7 1924

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH PENCIL OR PEN AND INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

0207 - 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92671

CERTIFICATE OF DEATH.

X 185 D 92671

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Smith

(a) RESIDENCE No Cooksville md ST., WARD Oakville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 22, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel Musgrove
(Address) Cooksville Md

15 Filed ..... 192 ..... ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~autopsy or inquiry.~~ find that said deceased came to Hus death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Fell from wagon

(duration) yrs. mos. 2 ds.

(Signed) H. H. Bonsal, M. D.
(Coroner.)

12-7, 192 (Address) 117 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cooksville Md	Nov 8 1924
20 UNDERTAKER	ADDRESS
Jas R West	Ellicott City Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

Rupek

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92672

CERTIFICATE OF DEATH.

10 D 92672

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Register St.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvina Rupek (Rupek)

(Residence in Baltimore: No. 414 S. Register St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: December 30, 1923
(Month) (Day) (Year)

7-AGE, yrs. 11 mos. 6 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto.

PARENTS.

10-NAME OF FATHER: John Rupek

11-BIRTHPLACE OF FATHER (State or Country): Russ. Poland

12-MAIDEN NAME OF MOTHER: Mary Kuta

13-BIRTHPLACE OF MOTHER (State or Country): Austria - Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): John Rupek

(Address): 414 S. Register

15- DEC 7 - 1924 (Date) (Registrar.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 5 1924, to Dec. 6 1924, that I saw h— alive on Dec. 5 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

R. Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. E. Kurz M. D.

Dec 6 1924 (Address) 711 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, 12/9, 1924

20-UNDERTAKER, William Crawford — ADDRESS, 711 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16b-001

16b 92673

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Townshend

(a) Residence No. Fowlersburg, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12/5/24

7-AGE. 20 minutes mos. ds. | If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS

10-NAME OF FATHER. Belt Townshend

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md do not know

12-MAIDEN NAME OF MOTHER. Helen Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md " "

14- (Informant) Ed Gaschs

(Address) Bladensburg md

DEC 7 - 1924

(Date Rec'd) ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 5th 1924

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1924 to Dec 5th 1924

that I last saw h[illegible] alive on 12/5/24 19

and that death occurred, on the date stated above, at 8.20 P m

The CAUSE OF DEATH* was as follows:

Premature Delivery

5 days Coma

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D

, 19 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 7 1924
20-UNDERTAKER	ADDRESS
F Gasch's Sons	Bladensburg md

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92674

CERTIFICATE OF DEATH.

40 D 92674

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1049 Greenmount Ave. Ward 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Carville

(a) Residence No. 1049 Greenmount Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Nov 1-1854

7-AGE: 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Samuel Carville

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Charity Hitchcock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-

(Informant): Mary Carville

(Address): 1049 Greenmount Ave.

15- DEC 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 6th 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1924 to Dec 6th, 1924 that I last saw h... alive on Dec 3rd, 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Acute Lung Affection

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. B. Hayes, M. D.

(Address) 1801 Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville

DATE OF BURIAL, ... 19....

20-UNDERTAKER: J. C. Windefeld

ADDRESS: 4 Greenmount Ave

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 92675

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General Hospital -

CITY OF BALTIMORE: (No. Lignor ave + Lanvale ST., 11 WARD)

2-FULL NAME David Grigg

(a) RESIDENCE No. 245 Richmond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18 1896.

7 AGE	28 Years	6 Months	16 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer -

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore - 074

(c) Name of employer unknown -

9 BIRTHPLACE (city or town) Florence (State or country) S.C.

PARENTS

10 NAME OF FATHER Wesley Grigg -

11 BIRTHPLACE OF FATHER (city or town) Florence (State or country) S.C.

12 MAIDEN NAME OF MOTHER Emily Washington

13 BIRTHPLACE OF MOTHER (city or town) Florence (State or country) S.C.

14 Informant Brother - (Sam Grigg)

(Address) 243 Richmond St -

15 Filed DEC 7 - 1924 JOSEPH R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4 1924

17

I HEREBY CERTIFY, That I attended deceased from 12/3/24, 19, to 12/4, 1924,

that I last saw him alive on 12/4, 1924,

and that death occurred, on the date stated above, at 2:55 P m.

The CAUSE OF DEATH* was as follows:

Bi lateral Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 12 hrs.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no -

What test confirmed diagnosis? Clinically -

(Signed) Clement L. Mowell, M. D.

, 19 (Address) West Baltimore General Hospital Lignor ave + Lanvale st -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL Dec 8 1924

20 UNDERTAKER Mark L. Elliott. — ADDRESS 1725 Ashland Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92676

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hopital ST., 10 WARD)

2-FULL NAME William Cuff

(a) RESIDENCE No. 821 Ashland ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Cuff

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercersburg, Pa.

PARENTS

10 NAME OF FATHER David Cuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mercersburg, Pa

12 MAIDEN NAME OF MOTHER Laura Cann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mercersburg Pa

14 Informant Municipal Hospital Records (Address)

Filed DEC 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-1, 1924, to 12-4, 1924

that I last saw him alive on 12-4, 1924

and that death occurred, on the date stated above, at 11 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Jones M. D.

12. 4 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Dec 8 1924
20 UNDERTAKER Mark A. Elliott	ADDRESS 1775 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Ewalt 2945 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

29-5 St Paul
D 92677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92677

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 St Paul ST., 12 WARD)

2-FULL NAME Ethel Wilhelm

(a) RESIDENCE NO. 2430 St Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (write the word)
Female	white	widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of Capt. Henry Wilhelm

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Lemuel Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Wetherald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Lemuel Hopkins
(Address) 2430 St Paul St

15 DEC 7 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1924, to Dec 6, 1924, that I last saw h~~e~~r alive on Dec 4, 1924, and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? usual

(Signed) G. Lenox Ewalt, M. D.

12/7, 1924 (Address) 2945 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Lo Cemetery - Irvelands Md	12/8 1924
20 UNDERTAKER	ADDRESS
Ulm Lwok	502 E. Fort Ave

N. B.—WHITE BLANKS, WITH CARBON SHEETS BETWEEN, ARE FURNISHED FOR USE IN TYPEWRITERS. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Kinney 2705 Harford Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92678

CERTIFICATE OF DEATH.

15 90

D 92678

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.) 1719 North Pulaski St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth M Jones

(a) Residence No. 1719 North Pulaski St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 20, 1906

7-AGE, 18 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Harford Co Md.

PARENTS.

10-NAME OF FATHER, Jacob H Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Daisy Pyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Harford Co Md.

14- (Informant) Daisy Phelps

(Address) 1719 N Pulaski St

15- Filed DEC 7 - 1924 ROBT. S. BRADLEY, Registrar.

Vital Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-6-1924

17- I HEREBY CERTIFY, That I attended deceased from May 19 17 to Dec 6 19 24

that I last saw h[illegible] alive on Dec 6 19 24

and that death occurred, on the date stated above, at. 6 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

12/6, 1924 (Signed) J Kinney M. D

(Address) 2705 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Deer Creek Cemetery Hall	Dec 16, 1924
20-UNDERTAKER. Wm Cook	ADDRESS 502 E Hoffman Ave

Shading to be carefully supplied. Age always to be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Gaeuty

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92679

CERTIFICATE OF DEATH.

16 001

D 92679

REGISTERED NO.

1-PLACE OF DEATH Herman Uzmire 6

CITY OF BALTIMORE: (No. ... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gaintz

(a) RESIDENCE NO. 162 Chester ST., ... WARD ...
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Ozmetz Neb
(State or country)

PARENTS

10 NAME OF FATHER Alexander Gaintz

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Anna Lehman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant ... Harry Brooks
(Address)

15 Filed ... 1924 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1924, to Dec 7, 1924.

that I last saw h[illegible] alive on Dec 7, 1924

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Congenital infant 2 lbs
Premature weight

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Walter Schuchmann, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

DATE OF BURIAL: 12/7 1924

ADDRESS

20 UNDERTAKER: Joch Lewis 1439 E Balto St

N. B.—WHEN BLANKS, not readily supplied, AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92680

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 92680

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 5 WARD) 2

2-FULL NAME Baby Neff

(a) RESIDENCE NO. 231 E Eden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			√	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Allen E. Neff.

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Estelle Blevins.

13 BIRTHPLACE OF MOTHER (city or town) Russia.
(State or country)

14 Informant Hosp Records.
(Address)

15 Filed ..... 1924 ROBERT R. KRAUTER, Registrar
Assist. Record Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 6, 1924, that I last saw him alive on Dec 6, 1924, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Intracranial Hem.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Philip Jacobson, M. D.

12/6, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 12/7 1924

20 UNDERTAKER Jack Levin 1439 E Balt St — ADDRESS

GIVE FULL INFORMATION, carefully supplied. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92681

D 92681

CERTIFICATE OF DEATH.

117

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St.) 27 WARD)

2-FULL NAME Robert E. Boyer.

(a) RESIDENCE NO. 4140 Belair Road, St. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Nettie Boyer.

6 DATE OF BIRTH (month, day, and year) January 3rd 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Boyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Ripley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Patent himself

(Address) 4140 Belair Road Balto Md

15 Filed DEC 7 1924 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12, 7, 24 19

17

I HEREBY CERTIFY, That I attended deceased from Dec 3 - , 1924, to Dec 7 - , 1924, that I last saw him alive on Dec 7 - , 1924, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer. Ch. Appendicitis

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 7-1924

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Evidence.

(Signed) Ed Horne, M. D.

. 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Dec 10 1924

20 UNDERTAKER: John Lucas — ADDRESS: 208 Belair

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

92682

M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88-003
88 D 92682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Petrecca

(a) RESIDENCE No 5th Ave & Trappe Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	whote	sihgle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 14/1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Libra Petrecca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catrina Mastrapolo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Libra Petrecca
(Address) 5th Ave & Trappe Rd

15 Dec DEC 7 1924 Registered

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- Struck by Automobile- accidental

(Inquest to be held Dec 8/24)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Bullen, M. D. (Coroner.)

508 E. North Ave Dec 6/24 (Address) (Date)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart December 8th	1924
20 UNDERTAKER John Merrick	ADDRESS 2008 Aliceanna

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Municipal Hospital Block 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dwyer Jr

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1858

7-AGE: 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): 040

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): unknown

PARENTS.

10-NAME OF FATHER: Wm Dwyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Catherine (unknown)

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Hospital Records

(Address) Bay View Hospital

15- Filed ... 192...

Registrar.

DEC 7 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12-5-24

17- I HEREBY CERTIFY, That I attended deceased from November 15 1924 to December 5 1924

that I last saw him alive on December 5 1924

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Bilateral Pyelo nephritis

Myocard. Interna & Cerebral hemorrhage

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Unknown Autopsy

Did an operation precede death? Yes Date of 11/17/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Lab Test

(Signed) Jos F Clarke M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel

DATE OF BURIAL: Dec 9 1924

20-UNDERTAKER: John Welsh

ADDRESS: 2008 Eutaw

should be carefully supplied. AGE should be stated exactly in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D792684 ✓ + 38

CERTIFICATE OF DEATH.

D 92684

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., 7 WARD)

2-FULL NAME Nathan Taylor

(a) RESIDENCE NO. 514 N. Bentz St. ST., Frederick, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Bentz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Daisy Yeh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Record

(Address): JOHNS HOPKINS HOSPITAL

15 DEC 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924, to Dec 5, 1924, that I last saw h[illegible] alive on Dec 5, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, primary

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wassermann test

(Signed) A W Jacobsen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md — DATE OF BURIAL: Dec 8 1924

20 UNDERTAKER: Thomas P. Rice — ADDRESS: Frederick Md

N.B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92685

CERTIFICATE OF DEATH.

D 92685
1-PLACE OF DEATH

Registered No. 1590

City of BALTIMORE: (No. 1519 Friendsbury St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Wehn

(a) Residence No. 1519 Friendsbury St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: George A. Wehn

6-DATE OF BIRTH (month, day and year): Nov. 1850

7-AGE: 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town): Hagerstown
(State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Sebastian Gillemeyer

11-BIRTHPLACE OF FATHER (city or town): (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Elizabeth McGuire

13-BIRTHPLACE OF MOTHER (city or town): London
(State or Country): England

14-(Informant): George S. Wehn
(Address): 2014 Clifton Ave.

15-DEC 7 - 1924 WALTER R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 4, 1924

I HEREBY CERTIFY, That I attended deceased from July 4th, 19[illegible] to Dec. 4, 1924
that I last saw h[illegible] alive on [illegible] 4, 1924
and that death occurred, on the date stated above, at 9.45 Pm.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Several (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What lesions confirmed diagnosis?

(Signed) John F. Sloan, M. D.

12-5-1924 (Address) 7 E. Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL, Dec. 9th, 1924

20-UNDERTAKER: Joseph B. Cook ADDRESS 1103 W. Baltimore St.

Entire blanks must be carefully supplied. Name should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92686 — 176 — 90 D 92686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Barnes

(a) RESIDENCE NO. 112 N. Columbia St. Riverside, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Elsie Barnes

6 DATE OF BIRTH (month, day, and year) May 16, 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Miscellaneous Contractors

(c) Name of employer Baltimore County Maryland

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Joshua Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sally Fountain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed DEC - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 5, 1924, that I last saw h... alive on Dec 5, 19..., and that death occurred, on the date stated above, at 8 P 8 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, cardiac hyp. & dilatation, mitral insuff. auricular fibrillation. Chronic passive congestion of lungs - viscera

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy findings

(Signed) Louis E Martin M. D.

12-6-1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 8 1924
20 UNDERTAKER Jos B Cook	ADDRESS W Balto

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. NAME should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92687

CERTIFICATE OF DEATH.

85 D 92687

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 N. Lexington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Thompson

(a) RESIDENCE No. 1204 N. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Thompson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Lynorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Joseph Wright (Address) 1439 Bambridge St.

15 Filed DEC 7 - 1924 ROBERT B. KRAUTER Registrar of Vital Records Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(duration) 12 hours

CONTRIBUTORY (Secondary): Fell against wall in cellar striking head

(duration) yrs. mos. ds.

(Signed) Thos B. Carlton, M. D. (Coroner.)

1924 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in Deaths from Violence, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magothy, Md.	Dec 8, 1924
20 UNDERTAKER: Mrs. Katie R. Williams	ADDRESS 322 N. Schroeder St.

TION is very important. See instructions on back of certificate

Copy of Death Certificate Required by Law. Care Required in Entering Items, So That It May Be Properly Classified. Department of Occupa

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153 D 92688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

2-FULL NAME Mrs. Hattie Catherine Motley

(a) RESIDENCE NO. 515 Collins Ave. ST. East Balto WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Motley

6 DATE OF BIRTH (month, day, and year) August 22-1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
58	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick County, Maryland.

PARENTS

10 NAME OF FATHER William Fulk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Catharine Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Md

14 Informant Jos. Wm. Motley. (Address) 515 Collins Ave

15 Filed DEC 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 5, 1924, to Dec 6, 1924, that I last saw her alive on Dec 6, 1924, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis of neck from abscessed tooth - left molar.

(duration) 2 wks. yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Dec 6-24

Was there an autopsy? No

What test confirmed diagnosis? Blood analysis. Clinical.

(Signed) A. McFord, M. D.

, 19 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 12/9 1924

20 UNDERTAKER William Cook — ADDRESS 52 E Read

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92689

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 20 E Rogers ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline P. Corl

(a) Residence No. 20 E Rogers ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Singer

6-DATE OF BIRTH (month, day and year) June 17-1852

7-AGE, 72 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Warren Balto Co

PARENTS.

10-NAME OF FATHER, Wm Bosley Corl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eliz Ann Baddes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Miss Margaret F Corl

(Address) Baltimore Md

15- Filed DEC 8 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 6th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1914, to Dec 6, 1924, that I last saw h[er] alive on Dec 5th, 1924, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

Of axilla, chest and

general carcinomatosis

(Duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Balto County

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E E Nichols, M. D.

12-7-1924 (Address) Pikesville Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel Ridge	Dec 8, 1924
20-UNDERTAKER	**ADDRESS**
Jos B Cook	1031 W Balto St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1888-008

D 92690

CERTIFICATE OF DEATH.

D 92690

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Jacob Moseman.

(a) RESIDENCE NO. 1316 Homewood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Margaret J.Moseman.

6 DATE OF BIRTH (month, day, and year) May 28, 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) W.M.R.R.Co.Crossing.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co.Md.

PARENTS

10 NAME OF FATHER John Moseman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Margaret J.Moseman.(wife).
(Address) 1316 Homewood Ave.

Filed DEC 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.6th, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull, Rupture of the liver, Shock. Knocked down and run over by a runaway two horse team.
Accidental Death. (Duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Dec. 7, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., 2 ds. In the State 70 yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Injured at Monument & Buren Sts. Dec. 4, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 8 1924

20 UNDERTAKER Geo. H. Little — ADDRESS Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92691

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 504 S. Streeper St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Margaret Nelson

(a) Residence No.... 504 S. Streeper St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. W. Nelson

6-DATE OF BIRTH (month, day and year) Aug. 24, 1866

7-AGE. 58 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... housewife 031

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Mueller

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Knieriem

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-

(Informant) William W. Nelson

(Address) 504 S. Streeper St

15-

Filed DEC 8 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 4. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept — 19.23 to Dec. 4 19.24

that I last saw h— alive on Dec 4 19.24

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular — Dis. of Heart —

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac paralysis

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Dr. P. O'Donnell, M. D.

, 19 (Address) 125 St Paul —

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cem.	Dec. 8, 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Eden St.

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 92692

CERTIFICATE OF DEATH.

D. 92692

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Summit Ave ST. 27 WARD)

2-FULL NAME Charles L. Walters

(a) RESIDENCE. NO. 19 Summit Ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1881

7 AGE	43 Years	9 Months	27 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Installer

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer Telephone & Balto Co

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Henry Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Fannie M Babylon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) PA

14 Informant Elva V Walter

(Address) 19 Summit Ave

15 [illegible]

DEC 8 - 1924 HOWARD R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to Dec 6, 1924, that I last saw him alive on Dec 6, 1924, and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Colon

(duration) 3 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Gilbert M. D.

, 19 (Address) 4814 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 6 1924
20 UNDERTAKER	ADDRESS
James Bailey Inc	1324 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92693

CERTIFICATE OF DEATH.

24 162

Register No. D 92693

1-PLACE OF DEATH

City of BALTIMORE: (No. 1737 Hanover St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Krueger

(a) Residence No. 1737 Hanover St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) Dec 4-1924

7-AGE. ....yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Herman Krueger

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Bridget Hughes.

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) Herman Krueger

(Address) 1237 Hanover

15-

Filed DEC 8 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 4 1924 to Dec 7 1924

that I last saw him alive on Dec 7 1924

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Thos H Stevens, M. D

2/7/25 (Address) 2878 Hartford

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Fairview DATE OF BURIAL, Dec. 8, 1924

20-UNDERTAKER. Chas. L. Heaver ADDRESS 1501 E. Fayette St.

Should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92694 — 1-PLACE OF DEATH — D 92694 REGISTERED NO.

CITY OF BALTIMORE: (NO. Pronounced dead at St. Joseph Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles M. Moran

(a) RESIDENCE NO 2762 Almeda Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred more than 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 18/1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Time keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md. Meter Works

9 BIRTHPLACE (city or town) (State or country) Long Island N.Y.

PARENTS

10 NAME OF FATHER Edward Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y. State

12 MAIDEN NAME OF MOTHER Elizabeth Cronk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y. Stae

14 Informant Dr. H.M.Robinson (Address) 2702 ALmeda Ave

15 Filed DEC 8 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(Fell instreet)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

(Signed) J. S. Watts, M. D. (Coroner.)

12-6-24 192 (Address) 508 E. Nor th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 8 1924

20 UNDERTAKER Harvey H. Witzke — ADDRESS 1534 W. Lombard

DEATH SHOULD BE CAREFULLY, ACCURATELY AND COMPLETELY FILLED OUT. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92695 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 92695**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 113 W York St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Stewart

(a) Residence No. 113 W. York St., 22 Ward
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sarah Stewart

6-DATE OF BIRTH (month, day and year): June 5, 1882

7-AGE: 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 074

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer: Chesapeake Co.

9-BIRTHPLACE (city or town) (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14-Informant: Sarah Stewart

(Address): 113 W. York St.

15-FILED DEC 8 - 1924 ROBERT E. KRAUTZ, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/6/24

17-I HEREBY CERTIFY, That I attended deceased from 11/25/24 to 12/6/24, that I last saw h alive on 12/5/24, and that death occurred, on the date stated above, at 3.30A.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Double

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchitis Chron (Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ray Bowles, M. D.

(Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Dec. 9, 1924

20-UNDERTAKER: J. H. Brown & Son — ADDRESS: 908 W. Monroe St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 92696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92696

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Gray

(a) RESIDENCE NO. 720 Belvue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Gray

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 33 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Delaware

PARENTS

10 NAME OF FATHER: John Cullan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware.

12 MAIDEN NAME OF MOTHER: Emma Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware.

14 Informant: Neighbors (Address)

15 Filed DEC 8 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-4-1924

17 I HEREBY CERTIFY, That I attended deceased from 12-3-24, 19 , to 12-4-24, 19 , that I last saw h/M alive on 12-4-24, 19 , and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopay? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. Lester M.D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Et — DATE OF BURIAL: Dec 8 1924

20 UNDERTAKER: J. W. Brown's Son — ADDRESS: 108 W. Mad[illegible]

N. B.—WRITE PLAINLY. PHYSICIANS should be careful to see that every item is correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that every item is correctly

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92697

D 92697.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ringgold

(a) RESIDENCE NO. 1025 Rear Race ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown Md.

PARENTS

10 NAME OF FATHER Perry Ringgold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chestertown Md

12 MAIDEN NAME OF MOTHER Bebie Gillmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown Md

14 Informant Municipal Hospital Records

(Address)

15 Filed DEC 8 - 1924 19 ROBERT N. GRAETER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 5 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 12 - 4 , 1924, to 12 - 5 , 1924, that I last saw her alive on 12 - 5 , 1924 and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis + Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial degeneration (duration) yrs. 2 mos (History)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clarke G. Dukes M. D.

12-5 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 12/9 1924

20 UNDERTAKER F. L. Broumel — ADDRESS Sandtown

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—D-10-21 92698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 92698

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 S Woodyear ST., 19 WARD)

2-FULL NAME William J Miller

(a) RESIDENCE No. 207 S. Woodyear ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER adolph Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Tavis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Tabor
(Address) 1232 W Hall St

15 Filed DEC 8 - 1924 WALTER R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5. 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1926. to Dec 5. 1924.
that I last saw him alive on Dec 5 1924.
and that death occurred, on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? NW
Did an operation precede death? NO Date of ...
Was there an autopsy? NO
What test confirmed diagnosis? Visual.
(Signed) Edgar C. Travers M. D.
. 19 (Address) 1500 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 9 1924
20 UNDERTAKER	ADDRESS
John J Fulda	1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

D 92699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92699
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 E. Clement St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Joseph Richards.

(a) Residence No.....417 E. Clement St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced. (Write the word.): Married.

5a-If married, widowed, or divorced. HUSBAND of (or WIFE of): Anna Belle Richards.

6-DATE OF BIRTH (month, day and year): Nov. 17, 1857.

7-AGE. 67 yrs. mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Joseph Richards.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Margaret Hunter.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland.

14-
(Informant): Anna Belle Richards, (Wife)
(Address): 417 E. Clement St.

15-
FILED DEC 8 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12.4.24

17- I HEREBY CERTIFY, That I attended deceased from 12.21.21, 19.., to 12.4.24, 19.., that I last saw h.. alive on 12.3.24, 19.., and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) P. Lilig B. Towles, M. D.

12.6.24 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery.

DATE OF BURIAL: Nov. 8, 1924

20-UNDERTAKER: A. Howard Evans

ADDRESS: 386 Fort Ave.

Burial Permit Issued

Please write clearly, using ink. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 92700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 S-16 St. ST., N WARD)

2-FULL NAME Theodore Lewis

(a) RESIDENCE No 501 S-16 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Lewis

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Spence

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Theodore Lewis
(Address) 501 S. 16th St.

15 DEC 8 - 1924

ROBERT H. KRAUTER
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) 3 days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. F. Stadel M. D.
(Coroner.)

Dec 7 1924 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec. 8 1924
20 UNDERTAKER Lilly & Feile	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92702 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital Registered No.....

City of BALTIMORE: (No. Lafayette Ave. & John St. St., 14 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Susan Griffith Riggs

(a) Residence No. Brookville Montgomery Co. Md. Ward Brookville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 0 ds How long in U. S., if of foreign birth? 68 yrs. 1 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 26 1856

7-AGE, 68 yrs. 1 mos. 11 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country), Brookville Md.

PARENTS.

10-NAME OF FATHER, John A Riggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Brookville Md.

12-MAIDEN NAME OF MOTHER, Annie E. Hutton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Brookville Md.

14- (Informant) John A Riggs (Address) Olney Md.

15- Filed ..... 19.. Registrar.

DEC 8 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1924, to Dec. 6, 1924, that I last saw h.. alive on Dec. 6, 1924, and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis and
Chronic myocarditis
Right Hemiplegia (Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast Subcutaneal polypi (Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of Dec 4 1924

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. Cagle Warfield Jr. M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Olney Montgomery Co. Md. DATE OF BURIAL, Dec 8 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

(over)

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 1924 92702

D 92702

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1140 Riverside Ave. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer E. Lowry

(a) Residence No. 1170 Riverside Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) ✓

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11/30/23.

7-AGE. .....yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of Industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Alfred N. Lowry

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Betty Lumpkin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14- (Informant) Alfred N. Lowry

(Address) 1170 Riverside Ave.

15- Filed DEC 8 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 6/1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1924 to Dec 6 1924

that I last saw him alive on Dec 6 1924

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY Convulsions

(Secondary)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed R R Cauthorn M. D

Dec 7 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cem.	11/8/24 19....
20-UNDERTAKER. Fred A. Krauter Jan.	ADDRESS 703 Hanover St.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92703

CERTIFICATE OF DEATH.

D 92703

Registered No. 164

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1642 N. Fulton Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Tindell

(a) Residence No. 1642 N. Fulton Ave st., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Tindell

6-DATE OF BIRTH (month, day and year) April 18th 1847

7-AGE. 77 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Joel B. Sutherland

(Address) 1642 N. Fulton Ave

15- DEC 8 - 1924 CHARLES R. KRAUTER Registrar of Vital Records Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1924 to Dec 6 1924

that I last saw h.. alive on Dec 6 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

General gun wear & body

cardiac weakness &c

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Eastman Jr. M. D

12/7, 1924 (Address) 1502 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Catholic Cem. DATE OF BURIAL, 12/10/24 19....

20-UNDERTAKER, Frank A. Fink ADDRESS 915 N. Gay St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

James Sheard

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 92704

D 92704

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital, WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Sheard

(a) RESIDENCE NO. 1636 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed DEC 8 - 1924 ROBT. P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-6 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-5 1924 to 12-6 1924

that I last saw him alive on 12-6 1924

and that death occurred, on the date stated above, at 9 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertension, Chronic Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude B. Hunt, M. D.

12. 6. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 12/9/24 1924

20 UNDERTAKER Byron Wright — ADDRESS 1218 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. INFORMATION is very important.

Cor.—1-12-23—M&T—100 Bks.

D 92705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92705

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 Orleans St ST., 6 WARD)

2-FULL NAME Charles Strassl

(a) RESIDENCE No 1919 Orleans St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 8/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	5	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House painter
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Strassl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Eleringer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Strassl (Address) 1919 Orleans St

15 DEC 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ... yrs. ... mos. ... ds.

(Signed) J S Wales, M. D. (Coroner)

12/6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gray Redeemer	Dec 9 1924
20 UNDERTAKER Wendell Dyer & Son	ADDRESS 37 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92706

CERTIFICATE OF DEATH.

Registered No. 22129

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 W. Stiel St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Diener

(a) Residence No. 17 W. Stiel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Dobe Diener

6-DATE OF BIRTH (month, day and year) —— 1849

7-AGE. 75 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Lester Diener

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Minnie Diener

(Address) 17 W. Stiel St.

15- ROBERT R. KRAUTER, Burial Permit Bookkeeper.

DEC 8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/7/24

17- I HEREBY CERTIFY, That I attended deceased from 12/1, 19 24 to 12/7, 19 24

that I last saw h~~im~~ alive on 12/7 19 24

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis a

Emphysema

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? urine test

(Signed) Dr Trumbower M. D.

12/8, 1924 (Address) 122 N Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Washington | DATE OF BURIAL. Dec 8, 1924

20-UNDERTAKER, S Levinson Bro | ADDRESS 1127 E. Balto St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92707. HEALTH DEPARTMENT—CITY OF BALTIMORE D 92707.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital - REGISTERED NO. 1476

CITY OF BALTIMORE: (No. Payne ave & Dukeland ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Thelma Miccichi

(a) RESIDENCE No. 4911½ Tyndale ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Frank Miccichi -

6 DATE OF BIRTH (month, day, and year) Mch 18 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Roanoke
(State or country) Va

PARENTS

10 NAME OF FATHER Mr Charles C. Bair

11 BIRTHPLACE OF FATHER (city or town) Jamestown
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Miss Rose Montgomery

13 BIRTHPLACE OF MOTHER (city or town) Chambersburg
(State or country) Penn.

14 Informant Mr Russell Bair - (Brother)
(Address) 524 S Bkup st

15 Filed DEC 8 - 1924 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/3, 1924, to 12/7, 1924,
that I last saw her alive on 12/3/24, 19—,
and that death occurred, on the date stated above, at 10.55 Am.

The CAUSE OF DEATH* was as follows:

Pelvic Cellulitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Clement R. Manual, M. D.

12-8, 19 24 (Address) West Baltimore General Hospital - Payne ave & Dukeland st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Dec 9" 1924

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Gilto

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

92708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 92708

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5904 Falls Road ST., 27 WARD)

2-FULL NAME Lydia A. Daily

(a) RESIDENCE NO. 5904 Falls Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse M. Daily

6 DATE OF BIRTH (month, day, and year): 1854-3-13

7 AGE: Years 65 Months 8 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Daniel Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Shaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Jesse Daily Mt Washington Md

15 Filed DEC. 8 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1924, to Dec. 7, 1924, that I last saw h-e alive on Dec 7, 1924 and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Grip - Chronic Intestinal -

Chronic Nephritis

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. H. Beelen, M. D.

12. 7. 1924 (Address) Mt Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion, Freeland Md. DATE OF BURIAL: Dec 10, 1924.

20 UNDERTAKER: Walter R. McNamee, ADDRESS: 4114 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92709 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92709

CERTIFICATE OF DEATH.

Registered No. 1 12

1-PLACE OF DEATH

City of BALTIMORE: (No. 2710 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wojciech Cieslot

(a) Residence No. 2710 Elliott St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 884 - May 3

7-AGE. 40 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Casmir Cieslot

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Josephine Cieslot

(Address) 2710 Elliott St.

15- Filed 192 [illegible] Registrar.

DEC 8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 6-1924

I HEREBY CERTIFY, That I attended deceased from Dec 1 19 24 to Dec 6 19 24

that I last saw him alive on Dec 5 19 24

and that death occurred, on the date stated above, at 9-a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Jameson M. D.

(Address) 806 N. Gay St.

*State the Disease Causing Death, as in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus Cem

DATE OF BURIAL. Dec. 9 1924

20-UNDERTAKER. Stephen Trulkowski

ADDRESS 1052 Kenyon Ave

Should be carefully prepared. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92710

CERTIFICATE OF DEATH.

100-001

D 92710

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3204 Garrison Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Swartwout

(a) Residence No. 3204 Garrison Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Capt Wm. Swartwout U.S.A.

6-DATE OF BIRTH (month, day and year) Mch 12 1839

7-AGE, 85 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, Levi Myer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N.Y.

12-MAIDEN NAME OF MOTHER, Margaret Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N.Y.

14- (Informant) Mary E. Neugebauer

(Address) 3204 Garrison ave

15- DEC 8 - 1924 ROBERT P. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 7. 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 25th 1924, to Dec 7 1924.

That I last saw her alive on Dec. 6 1924.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchitis & Age

85 yrs. (Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?* Symptoms

(Signed) D A Oldham M. D.

Dec 8 1924 (Address) 210 E. Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Norfolk Va	Dec. 9 1924
20-UNDERTAKER.	ADDRESS
John O Mitchell	1201 W. Fayette St.

Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Filled in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Rks.

17384 D 92711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92711

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 25 ST., WARD)

2-FULL NAME Ella Jones

(a) RESIDENCE No. 9 Ridgely St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leroy Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Cora Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 8 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1924, to Dec 6, 1924, that I last saw her alive on Dec 6, 1924, and that death occurred, on the date stated above, at 6 55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. (?) mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund W. Kemper M. D.

12/7, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Cem Dec 8 1924

20 UNDERTAKER — ADDRESS

Samuel G Bradley Baltimore

N.B.—WHITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92712

CERTIFICATE OF DEATH.

57 D 92712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1629 Darley Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hilkle

(a) RESIDENCE. No. 1205 Riverside Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 15 1853

7 AGE — Years: 69 — Months: 3 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dryks Borkulein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Joseph Hilkes 1629 Darley ave

15 Filed DEC 8 - 1924 19 Registrar

Rental Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 15 1923, to Dec 6 1924, that I last saw her alive on Dec 5 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetic coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What lest confirmed diagnosis? Lab

(Signed) Wm E Stigler, M. D.

12/6, 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Vilulent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: 12-9 1924

20 UNDERTAKER: E & B Hartle

ADDRESS: 115 E North Ave

N. B.—WHITE PAPER must be carefully supplied. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E&R R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92713

CERTIFICATE OF DEATH.

D 92713

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 E Clement St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Zenk.

(a) Residence No. 415 E Clement St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Zenk

6-DATE OF BIRTH (month, day and year) April 24-1863

7-AGE: 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- (Informant) John Zenk.
(Address) 415 E Clement St

15- DEC 8 - 1924 Bridal Permit Registry.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924 to Dec 7, 1924

that I last saw h. alive on Dec 7, 1924

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. B. Campbell M. D.

Dec 8, 1924 (Address) 164 S Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co. DATE OF BURIAL, Dec 11, 1924

20-UNDERTAKER: E & B Hook ADDRESS 115 E Hoffman

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 92714 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2656 Hungton ave. St., 17 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Todd

(a) Residence No. 2650 Hungton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Todd

6-DATE OF BIRTH (month, day and year) Dec 14 1864

7-AGE. 59 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Harford Md.

PARENTS.

10-NAME OF FATHER, Robt Todd.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Susie Stafford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Carrie Todd. (Address) 2650 Hungton ave.

15- Filed DEC 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 7, 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1924 to Dec. 7 1924, that I last saw him alive on Dec 7 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Cordiac Dilatation

Sudden

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. C. Richardson M. D.

, 1924 (Address) 112 W. 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	Dec 10, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Should be carefully supplied. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

Dr Buck 2811 St Paul St

D 92715 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92715

CERTIFICATE OF DEATH.

(Walbrook Ellamont)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Prince of Peace Church St., 8 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur C Leonard

(a) RESIDENCE NO. 2811 St Paul St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella F Leonard

6 DATE OF BIRTH (month, day, and year) Feb 24 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	68	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William Leonard

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Matilda Oliver

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Ella F Leonard (Address) 2811 St Paul St

15 DEC 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1924, to Dec 6, 1924, that I last saw h alive on Dec 5, 1924 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(Embolism of Coronary Artery)

(duration) — yrs. — mos 21 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hobart Buck, M. D.

12/7, 1924 (Address) 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Dec 1924
20 UNDERTAKER W. Cook	ADDRESS 5022 Yorktown

N.B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Jones, 720 N Gilmor

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92716

CERTIFICATE OF DEATH.

90 D 92716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 South Gilmor ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enoch L. Grumbine

(a) RESIDENCE No. 215 South Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Widowed

5a (If married, widowed, or divorced) HUSBAND of (or) WIFE of Lottie Grumbine

6 DATE OF BIRTH (month, day, and year) Apr 1, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Frederick, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Gilbert

(Address) 711 Homestead Ave.

DEC 8 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 6 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23rd, 1923, to Dec 6, 1924, that I last saw h[illegible] alive on Dec 5th, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) N G Jones, M. D.

12/7, 1924 (Address) 720 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Dec 9 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Nav

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D A K O

Spec.—1-10-21—M&T—1500 Bks.

D 92717. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 92717.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Woodyear ST., 16 WARD)

2-FULL NAME minty Henson

(a) RESIDENCE NO. 1131 Woodyear ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Henson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launders 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Guilford, Co. Md.

PARENTS

10 NAME OF FATHER Jonas Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daughter

(Address) 1131 Woodyear St

15 Filed [illegible] 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5- 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-5- , 1924, to 12-5- , 1924.

that I last saw her alive on 12-5- , 1924.

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank H. Saunders, M. D.

12-7 1924 (Address) 1123 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Dec 8 1924

20 UNDERTAKER Sam'l N. Chase & Son ADDRESS 1605 N. Eden

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001

D 92718

REGISTERED NO.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Springfield ST., 9 WARD)

2-FULL NAME James Ramsey

(a) RESIDENCE NO. 1206 Springfield ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Lee Ramsey

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McMullan

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER James Madrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Emma Dec?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Rose Lee Ramsey

(Address) 1100 E. North Avenue

15 DEC 8 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-7 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov-1-, 1924, to Dec-7-, 1924

that I last saw him alive on Dec-6-, 1924

and that death occurred, on the date stated above, at 1:10 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. X mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

Dec 7, 1924 (Address) 203 E. McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Raleigh N C

DATE OF BURIAL Dec 8 1924

20 UNDERTAKER Sam'l. Chase Howard & Madison

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92719

101-001

CERTIFICATE OF DEATH.

D 92719

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 16 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mavis Johnson

(a) RESIDENCE No. 1068 N. Mount ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 09 05

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Porter 70

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Katie Brown

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Husband Present (Address)

15 DEC 8 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3/24

17 I HEREBY CERTIFY, That I attended deceased from 12/3/24, 19 ..., to 12/3/24, 19 ..., that I last saw h[illegible] alive on 12/3/24, 19 ..., and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Linsley, M. D.

12-8, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn St. Mary's	12-9 1924
20 UNDERTAKER	ADDRESS
Sam'l M. Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92720

D 92720

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1045 Guilford Avenue St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Scott Lee

(a) Residence No. 1045 Guilford Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred About 78 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Lee

6-DATE OF BIRTH (month, day and year): Do not know

7-AGE: About 78 yrs. -- mos. -- ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: Andrew Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12-MAIDEN NAME OF MOTHER: Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14- (Informant): Mrs. Martha Cotter

(Address): 1045 Guilford Avenue

15- DEC 8 - 1924 [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924 to Dec 5, 1924

that I last saw h[illegible] alive on Dec 4, 1924

and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 1 hour

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Dreifl M. D.

12/6, 1924 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL, 12/9, 1924

20-UNDERTAKER: Henry W. Myers & Son

ADDRESS 805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY, if possible, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

9272 D

CERTIFICATE OF DEATH.

15 89

D 9272

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4007 Penhurst Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche K. Straus

(a) Residence No. 4007 Penhurst Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 13 ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry W. Straus

6-DATE OF BIRTH (month, day and year): June 23, 1872

7-AGE: 52 yrs. 5 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS

10-NAME OF FATHER: Ludwig Kraus

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Betty Haller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): U.S.A.

14- (Informant): Henry L. Straus

(Address): 4007 Penhurst Ave.

15- Filed DEC 8 - 1924 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12-6-1924

17- I HEREBY CERTIFY, That I attended deceased from July 19 22 to Dec 6 19 24

that I last saw h[illegible] alive on Dec 6-1924 19

and that death occurred, on the date stated above, at 5a, m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt F Stanclift M. D

, 19 (Address) 815 E Lit

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cemetery

DATE OF BURIAL, 12/8 19 24

20-UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill this CHOSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92722

Registered No. 129 D 92722

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 S. Wolfe St., N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Tajkowski

(a) Residence No. 517 S. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 30 1858

7-AGE. 66 yrs. mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Mr. Henry . Piwinski

(Address) 517 S. Wolfe Street

15- DEC 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 6 / 1924

I HEREBY CERTIFY, That I attended deceased from Oct 5 19 24 to Dec 5 19 24

that I last saw h[illegible] alive on Dec. 5 19 24

and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia Heart failure

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Wm H Ballinger M. D.

12/6 1924 (Address) 1625 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross German Hill Rd.	Dec 9 19 24

20-UNDERTAKER. John M Weber ADDRESS 1803 Bank St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92723 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92723

CERTIFICATE OF DEATH.

Registered No. 114

1-PLACE OF DEATH

City of BALTIMORE: (No. 527 N. Ellwood ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Homer

(a) Residence No. 527 N. Ellwood ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, White

5-Single, Married, Widowed, M. or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Savannah

6-DATE OF BIRTH (month, day and year) July 5, 1861

7-AGE 63 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Building Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS

10-NAME OF FATHER, John H. Homer

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Elizabeth Rodgers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Savannah Homer

(Address) 527 N. Ellwood ave

15- DEC 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 4, 1924 to Dec 6 1924

that I last saw him alive on Dec 6 1924

and that death occurred, on the date stated above, at 3.20 A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. R. Dwight, M. D

, 19 (Address) 265 Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Dec 9, 1924

20-UNDERTAKER. Zurkler & Zurkler — ADDRESS 1739 Eager st

should be carefully supplied. AGE should be stated EXACTLY. If unknown, APPROXIMATE should be given. Use words in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

92724 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92724

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. U.S. Marine Hospital St., 12 WARD)

2-FULL NAME Jesse C Oakley

(a) RESIDENCE NO. 12 & 21st Street ST., E21 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	divorced

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ Carrie Winters

6 DATE OF BIRTH (month, day, and year) Mar 25 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical 009

(b) General nature of industry, business, or establishment in which employed (or employer) War Dept. U.S.A.

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) Moratico. (State or country) Virginia

PARENTS

10 NAME OF FATHER Isaac Oakley

11 BIRTHPLACE OF FATHER (city or town) Newyork (State or country) Newyork

12 MAIDEN NAME OF MOTHER Ida B. Jett

13 BIRTHPLACE OF MOTHER (city or town) King George Co. (State or country) Virginia

14 Informant Ida B Oakley (Address) 12 [redacted]

15 DEC 8 - 1924 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1924, to Dec 7, 1924, that I last saw him alive on Dec 7, 1924, and that death occurred, on the date stated above, at 10 30a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary Chronic

(duration) 4 yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Emphysema (duration) 0 yrs. 8 mos. ? ds.

18 Where was disease contracted if not at place of death? Edgewood Arsenal, Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical and Laboratory

(Signed) M. A. Foster, M. D.

Dec 8, 19 (Address) U S Marine Hosp 310 Remington Bltg Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spotsylvania Va — DATE OF BURIAL Dec 9 1924

20 UNDERTAKER E Le Roy Stifflee — ADDRESS 125 E North Ave

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92725

CERTIFICATE OF DEATH.

66

D 92725

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W. Franklin St., 17 WARD)

2-FULL NAME Issac Gibbons

(a) RESIDENCE NO. 702 W. Franklin St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1854 Gen'y

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Florence Samuels
(Address) 702 W. Franklin St.

15 Filed DEC 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inq'y (Inquest, autopsy or inquiry.) find that said deceased came to h is death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Dec. 6, 192 4 (Address) 2 North Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. If infants' names may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—L-1021—M&T—1500 Bks.

Bar Abramowitz 92726

D 92726

D 175360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92726

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 131

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) No

2—FULL NAME Bar Abramowitz

(a) RESIDENCE No. 3812 Eastern Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Celia Abramowitz

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Cecelia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 DEC 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 - 1924 to Dec 8 - 1924, that I last saw him alive on Dec 8 - 1924, and that death occurred, on the date stated above, at 8.25 a m.

The CAUSE OF DEATH* was as follows:

1) Postoperative Hemorrhage (Secondary anemia) following perineal prostatectomy — 2) Pyelonephritis (9 months) (duration) yrs. 9 mos ... da.

CONTRIBUTORY (Secondary): Bronchopneumonia (duration) ... yrs. ... mos. 1½ da.

18 Where was disease contracted if not at place of death? In Baltimore.

Did an operation precede death? Yes Date of Nov 17th 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. H. Goodman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION OR REMOVAL	DATE OF BURIAL
Bals. Mt. Lebanon	12-8- 1924
20 UNDERTAKER	ADDRESS
Fast Lewis	1439 E. Bals.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- that it may be properly classified. CAUSE OF DEATH in plain terms, so TION is very important. See instructions on back of certificates.

Spec.—1-10-24—M&S—1500 Blks.

D 92727.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 92[illegible]

REGISTERED NO.

1-PLACE OF DEATH University Hospital.

CITY OF BALTIMORE: (No. Lombard & Green ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Wiley Stansbury

(a) RESIDENCE NO. 9th & Brooklyn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Stansbury

6 DATE OF BIRTH (month, day, and year) Aug 8, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Md

12 MAIDEN NAME OF MOTHER Harriet Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant [illegible] Stansbury

(Address) 9th & Brooklyn

15 Filed DEC 8 - 1924

[illegible] R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6. 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 6. 1924. to Dec 6. 1924.

that I last saw him alive on Dec 6. 1924.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis.

over

(duration) yrs. 9 mos.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. 9 mos.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of Dec 6.

Was there an autopsy? no.

What test confirmed diagnosis? Operation.

(Signed) [illegible], M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westorn DATE OF BURIAL Dec. 10 1924

UNDERTAKER Maged W. Flynn ADDRESS 1422 Light.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92728

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Gutman ave ST., 9 WARD)

2-FULL NAME David S. Ward.

(a) RESIDENCE NO. 602 Gutman ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margret A. Ward

6 DATE OF BIRTH (month, day, and year): Nov. 20-1862

7 AGE: 62. (Years / Months / Days / If LESS than 1 day, ...hrs. or ....min.)

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Collector
(b) General nature of industry, business, or establishment in which employed (or employer): City Dairy
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Y.

PARENTS

10 NAME OF FATHER: Wm Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Catherine Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant (Address): Margret A. Ward. 602 Gutman ave

15 DEC 8 - 1924

19 Robert P. Hamilton Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1924

17 I HEREBY CERTIFY, That I attended deceased from December 2 1922, to Dec 6 1924.
that I last saw him alive on Dec 5 1924,
and that death occurred, on the date stated above, at 1.30 A m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Convulsion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F. Tonry, M. D.
Dec. 1924 (Address) 414 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec. 9 1924

20 UNDERTAKER: Robt J Turner Jr — ADDRESS: 1442 N Broadway

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITIONS TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92729

154-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 734 N Crace St. 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Joseph Reeder

(a) RESIDENCE. No. 734 N Crace St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7/1924

7 AGE — Years — Months — Days — If LESS than 1 day, — hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph J. Reeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary M. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Joseph Tucker 734 N. Crace St

15 Filed ..... 19.... Registrar

Robert P. Harrison

DEC 8 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1924, to Dec 7, 1924

that I last saw h— alive on Dec 7, 1924

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Congenital Deformity (Crew),

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell, M. D.

Dec 9, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: 12-8 1924

20 UNDERTAKER: Dennis Dignan & Son — ADDRESS: Fulton & Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUP
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92730

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 N Belnord Ave 6 St., ... Ward) Registered No. 129

2-FULL NAME David Hopkins

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 100 N Belnord Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Hopkins

6-DATE OF BIRTH (month, day and year) March 9 1853

7-AGE, 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Richard Hopkins

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bridget McDonough

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Ireland

14- (Informant) Alice Hopkins
(Address) 100 N Belnord Ave

15- Filed ..... 192 .....
Registrar.

DEC 8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 7th

17- I HEREBY CERTIFY, That I attended deceased from Dec 5, 1924, to Dec 7, 1924, that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at 8:20 A.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. J. Valentine M. D.

Dec 7, 1924 (Address) 17 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem — DATE OF BURIAL, Dec 10, 1924

20-UNDERTAKER. James Dignan & Son. — ADDRESS 1000 S Paca St

All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9273F

CERTIFICATE OF DEATH.

D 9273F

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5313 Melvin ave St., 27 Ward) 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Adelaide Kennett

(a) Residence No. 5313 Melvin ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Fem~~

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John R Kennett

6-DATE OF BIRTH (month, day and year) Sept 11- 1880

7-AGE. 44 yrs. 2 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wife (37)

(b) General nature of industry, business, or establishment in which employed (or employer) Home Work

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS

10-NAME OF FATHER, W= R Passano

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Marion Grant

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) John R Kennett

(Address) 5313 Melvin ave

15- Filed DEC 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 7/24

17- I HEREBY CERTIFY, That I attended deceased from June 11 1924 to Dec. 7 1924

that I last saw her alive on Dec. 6 1924

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? ~~2nd~~

Did an operation precede death? 2nd Date of

Was there an autopsy? 2nd

What test confirmed diagnosis? ~~Physical Signs~~

(Signed) R. C. Metzel M. D

Dec. 7 1924 (Address) 1403 W. Mount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount | DATE OF BURIAL. Dec 9... 1924

20-UNDERTAKER, W. M. Rouken | ADDRESS 2238 W Mount Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92732 / 17632 /

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92732

118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 20

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Funk

(a) RESIDENCE NO. 101 S. Catherine ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Theresa Funk

6 DATE OF BIRTH (month, day, and year) June 20 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —"— 014

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10 NAME OF FATHER John Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Mary Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 8 - 1924, 19 Robert J. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1924, to Dec 6, 1924, that I last saw h... alive on Dec. 6, 1924, and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

following Gastro-Enterostomy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11/3/24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Cecil H Bagley, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 9 1924
20 UNDERTAKER	ADDRESS
F. B. Wappuit	1850 N. Gallo St

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92733

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 E. Baltimore ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marinda Reed Bowling

(a) RESIDENCE NO. 1923 E. Baltimore ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner 086

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. I. Bowling

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia C. Hamel

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Miss Amelia Bowling
(Address) 1923 E. Baltimore St.

15 Filed ....., 19.... Robert P. Harrison, Registrar

DEC 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1923, to Dec 4, 1924.

that I last saw h[illegible] alive on Dec. 3, 1924,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis – Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted / If not at place of death?.....

Did an operation precede death? nr Date of

Was there an autopsy? nr

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lutz M. D.

12-6, 1924 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. DATE OF BURIAL: Dec. 9 1924

20 UNDERTAKER: Wm. C. Black, ADDRESS: 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92734

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH Church Home and Infirmary

Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen May Doenges

(a) Residence No. 1906 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-(Single, Married, Widowed, or Divorced, (Write the word.)) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Nov. 14, 1894

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS:

10-NAME OF FATHER, George L. Doenges

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Anna Atwell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14-

(Informant) Geo. L. Doenges

(Address) 1906 McElderry St Baltimore, Md.

15-

Filed DEC 8 - 1924

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1924 to Dec 6, 1924

that I last saw h.. alive on Dec 6, 1924

and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analysis Blood chemistry

(Signed) W. W. Gray M. D

, 19 (Address) 1401 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemetery	11/9/24 19....
20-UNDERTAKER.	**ADDRESS**
Joseph Ahrens	221 Bway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S DESCRIPTION is very important. Exact statement of OCCUPATION is very important. Cause of death must be in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92735

CERTIFICATE OF DEATH.

1/117

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 25 WARD)

2-FULL NAME Master Stanley Reese Winter

(a) RESIDENCE NO. 2405 James St. ST. Paul's WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Balto Md. yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	School Boy.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of School Boy.

6 DATE OF BIRTH (month, day, and year) July 20 - 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm H Winter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Francis Hooper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mother.

(Address) 2405 James St. Druid Park.

15 DEC 8 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 , 1924 , to Dec 8 , 1924 ,

that I last saw him alive on Dec 8 , 1924 ,

and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis - Gangrene -

(duration) yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis - Septicemia -

(duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Dec 7-1924

Was there an autopsy? No

What test confirmed diagnosis? Gustin Christ -

(Signed) Dr Lotus, M. D.

, 19 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL 12/11 1924

20 UNDERTAKER Geo Lemtach & Son ADDRESS 6031 W Pratt St

N.B.—WRITE PLAINLY, WITH UNFADING INK. ... should be stated EXACTLY. PHYSICIANS should ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C8

Spec—12-23-21—E.B.R.S.—400 Bks.

Rayer. 27

D 92736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92736

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1443 N. Gay st St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rayer.

(a) Residence No. 1443 N. Gay st St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 7 1867

7-AGE 57 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED.
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt. Md.

PARENTS.

10-NAME OF FATHER, C. Behn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Behn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt Md

14-
(Informant) Father. Rayer.
(Address) 1443 N. Gay st.

15-
Filed DEC 8 1924 Chas. P. Garrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year), Dec 7 1924

17- I HEREBY CERTIFY, That I attended deceased from ~~.....~~ 1924 to Dec 7 1924, that I last saw h~~er~~ alive on Dec 6 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Carcinomatosis Metastases
following Carcinoma of
left breast
(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1916

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. Hurdon Simpson M. D.

1787. 1924 (Address) 16 E. Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hamilton Cem.	Dec 9 1924
20-UNDERTAKER. Cemetery Co.	ADDRESS
Geo. F. Ruth	1736 Hereford Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important ... instructions on back of certificates.

Health Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D 92737. 94

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92737

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 1

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Golden

(a) RESIDENCE NO. 203 S Bethel St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Melvin Golden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mandy Wiggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Relative JOHNS HOPKINS HOSPITAL

15 Dec 8 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1924 to Dec 4 1924, that I last saw h alive on Dec 4, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yr (?) mos ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 1 mos (?) ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund N. Kuper, M. D.

12/7 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec 10 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 8 - 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92738

CERTIFICATE OF DEATH.

D 92738

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

2-FULL NAME Minnie Heberle

(a) RESIDENCE No. 2605 Bernard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L Heberle

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mercy Hospital
(Address)

15 DEC 8 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8/24 19

17

I HEREBY CERTIFY, That I attended deceased from 12/4/24, 19 ... to 12/8/24, 19 ... that I last saw h— alive on 12/8/24, 19 ... and that death occurred, on the date stated above, at 1:00 a. m.

The CAUSE OF DEATH* was as follows:

Primary Cause unknown
Myocarditis (Chronic)

..... (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Mercy, M. D.

19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Humphries	Dec 11 1924
20 UNDERTAKER Chenowith Son	ADDRESS 3677 Chestnut

PRINT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92739

CERTIFICATE OF DEATH.

D 92739

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3412 Hickory Ave 13 St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jennie Mc Fatridge

(a) Residence No. 3412 Hickory St. ..... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed or divorced HUSBAND of (or WIFE of) George Mc Fatridge

6-DATE OF BIRTH (month, day and year) March 3, 1869

7-AGE 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) G Tennyson

(Address) 343 E 21st

15- Filed ..... 19.....

Robert P. Harrison, Registrar.

EC 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1924 to Dec 7 1924

that I last saw her alive on Dec 7 1924

and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) John H Mussey M. D.

19 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20-PLACE OF BURIAL, REMOVAL, OR CREMATION: Loudon Park Pleasant Hill Co

DATE OF BURIAL. Dec 10. 1924

20-UNDERTAKER. Chenoweth & Son

ADDRESS 3617 Chestnut Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92740

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Susan Garlitz

(a) Residence No. Overlea Md. St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Garlitz

6-DATE OF BIRTH (month, day and year) Unknown

AGE About 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work U.S. Postmistress

(b) General nature of industry, business, or establishment in which employed (or employer) Clerical 109

(c) Name of employer U.S. Government

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Thelma Garlitz

(Address) St Joseph Hospital

15- DEC 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1924 to Dec. 8, 1924

that I last saw her alive on Dec. 8, 1924

and that death occurred, on the date stated above, at 1.30 pm.

The CAUSE OF DEATH* was as follows:

11 Uterine Intraposition "Operation for Cystocele, Prolapsus uteri, Rectocele"

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 1, 1924.

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) E. M. Rhodes M. D

19 (Address) St. Joseph Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Frostburg, Md. DATE OF BURIAL, Dec 9 1924

20-UNDERTAKER Wm. Cobb ADDRESS 502 E Fort Ave

NOTE—WRITE PLAINLY WITH INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92741

CERTIFICATE OF DEATH.

D 92741

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital, ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marie Niegsch

(a) Residence No. 2834 Parkwood Ave Ward .....

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Paul Niegsch

6-DATE OF BIRTH (month, day and year) Nov. 11. 1888

7-AGE. 36 yrs. mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Paul Niegsch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Volker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Paul H. Niegsch

(Address) 2834 Parkwood Ave

15- DEC 9 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1924 to Dec. 8 1924

that I last saw her alive on Dec. 8 1924

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchialpneumonia

Chronic Nephritis

Uremia

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial In-

sufficiency (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical, Chem. + Labor.

(Signed) B. McRhoades M. D

, 19 (Address) St. Joseph Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cemetery Emmanuel. DATE OF BURIAL. Dec. 10, 1924

20-UNDERTAKER. Wm. Ps John H. Teufel & Son ADDRESS 801 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92742

CERTIFICATE OF DEATH.

90 D 92742

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2100 Barclay. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Camp

(a) Residence No. 2100 Barclay. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Joseph Camp

6-DATE OF BIRTH (month, day and year): June 24/1837

7-AGE: 87 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Lancaster Pa.

PARENTS:

10-NAME OF FATHER: John Weidler.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa.

12-MAIDEN NAME OF MOTHER: Not Known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14- (Informant): Chas. H. Camp Sr.

(Address): 2025 E. Madison St.

15- DEC 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12-5-24

17- I HEREBY CERTIFY, That I attended deceased from 11-20 19 24 to 12-5 19 24

that I last saw h[illegible] alive on 12-4 19 24

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(Duration) ..... yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(Duration) ..... yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Fred Davis M. D

19[illegible] Address 2100 Barclay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Marys Downs DATE OF BURIAL: Dec 9-1924

20-UNDERTAKER: E A Rudelfield ADDRESS 2201 Greenmount Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Cor.—1-12-23—M&T—100 Bks.

George Parrish

D 92743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Union Memorial Hosp. ST., (WARD)

REGISTERED NO. 188-002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marler G. Parrish

(a) RESIDENCE No. 3206 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1918.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6. yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER M. Parrish.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Annie Cheny.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14
Informant Annie Cheny.
(Address) 3206 Barclay St

15
Filed DEC 9 - 1924 192
ROBT. R. KRAUTEN, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.
The CAUSE OF DEATH* was as follows:

Injuries from
Auto accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)
Dec 8, 1924 (Address) 5532 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel. Cty.

DATE OF BURIAL Dec. 9 1924

20 UNDERTAKER Adolphus Hasted

ADDRESS 151 Maiden Lane Catonsville, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92744 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. St. Joseph's Hosp St. 5 Ward) Registered No. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Grenage

(a) Residence No. 1219 E. Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Elijah Grenage

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Charity Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-(Informant) Nathaniel Grenage

(Address) Baltimore St.

15- DEC 9 - 1924 J. H. L. B. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1924, to Dec 6, 1924, that I last saw h. alive on Dec 6, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with Uremia

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Sybert M. D

, 19 (Address) St Jos Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. H.P. Cemetery Co. DATE OF BURIAL. Dec 1924

20-UNDERTAKER. Samuel A. Smedley ADDRESS 1 Bidle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92745

D 92745

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 934 S. Third St. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Theresa Frisch

(a) Residence No..... 934 S. Third St. St., 76 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Frisch

6-DATE OF BIRTH (month, day and year) Dec. 3-1867

7-AGE, 57 yrs. 0 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Staraut

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)..... Joseph Frisch

(Address)..... 934 S. Third St.

15-

DEC 9 - 1924

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 5-1924

17- I HEREBY CERTIFY, That I attended deceased from 11/4, 19.24 to 12/5, 19.24

that I last saw h.r alive on 12/5/24 19.....

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) yrs. 16 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. H. Gandell, M. D.

12/8, 1924 (Address) 633 - S - 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Sacred Heart — DATE OF BURIAL, Dec. 9th, 1924

20-UNDERTAKER, Lilly & Zuiler — ADDRESS 403 S. Wolfe St.

EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92746

CERTIFICATE OF DEATH.

31 D 92746

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No 2232 Bank ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin McDonough

(a) RESIDENCE No 2232 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1849

7 AGE: Years 75; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Captain

(b) General nature of Industry, business, or establishment in which employed (or employer): Sailing Vessel

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael McDonough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McDonough

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary Lynch

(Address) 2232 Bank St

15 Filed DEC 9 - 1924 ROBT. R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1924, to Dec 5th, 1924, that I last saw him alive on Dec 5th, 1924, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C Wade, M. D.

19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec. 9 1924

20 UNDERTAKER: J A Moran — ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

92747

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-09

VD 92747

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hotel Franklin ST. 17 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clyde Richards (St.; 0 yrs. 0 mos. 7 ds.)

(Residence in Baltimore: No. Hotel Franklin (Resident-Winchester Va.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male | 4-COLOR OR RACE White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Dec 8 (Month), 19 (Day), 19 (Year)

7-AGE ... yrs. ... mos. ... ds. | If LESS than 1 day, 4 hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE (State or country) Hotel Franklin

PARENTS

10-NAME OF FATHER James Lewis Richards

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Soda Richards

13-BIRTHPLACE OF MOTHER (State or country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L. E. Richards

(Address) Hotel Franklin

15 DEC 9 - 1924 (Date Received) 191 ROBERT B. KRANTZ REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 8 (Month) 8 (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1924, to Dec 8, 1924, that I saw h— alive on Dec 8, 1924, and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

5 hr (Duration) ... yrs. ... mos. ... ds. after birth

Contributory (SECONDARY) Premature birth

(Duration) ... yrs. ... mos. ... ds.

(Signed) A L Leyhe M. D.

Dec 8, 1924 (Address) 710 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. ds. In the State 0 yrs. 0 mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Winchester-Va

19-PLACE OF BURIAL OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec 9, 1924

UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92748

CERTIFICATE OF DEATH.

D 92748

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. In front of 317 N.Gay St ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C.Smyth.

(a) RESIDENCE NO. 708 Aisquith Street. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Katie C.Smyth.

6 DATE OF BIRTH (month, day, and year) December 22,1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Nat.Marine Bank.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Smyth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Coffey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Katie C.Smyth.(wife).
(Address) 708 Aisquith Street.

15 Filed DEC 9 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.7- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt, M. D.
(Coroner)

Dec. 8, 1924. Address) 1017 S.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 10th 1924
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92749

CERTIFICATE OF DEATH.

D 92749

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Not known

CITY OF BALTIMORE. (No. Annapolis Ave ST. 25 WARD)

2-FULL NAME James W. Oliver

(a) RESIDENCE. NO. Annapolis Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant James W. Oliver
(Address) Not known

15 Filed DEC 9 - 1924 ROBT. R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 6, 1924, that I last saw him alive on Dec 4, 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis general

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Raymond Gluum, M. D.

Dec 8, 1924 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 9 1924
20 UNDERTAKER	ADDRESS
Samuel Knowles	N Baddock

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

Spec.—1-10-24—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92750

CERTIFICATE OF DEATH.

D 92750

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

2-FULL NAME Barbara Morris

(a) RESIDENCE NO. 628 N. Belnord Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Harry Morris

6 DATE OF BIRTH (month, day, and year) Oct 27/70

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Backs

11 BIRTHPLACE OF FATHER (city or town) Ger. (State or country)

12 MAIDEN NAME OF MOTHER Margt. ?

13 BIRTHPLACE OF MOTHER (city or town) Ger (State or country)

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 27 1924, to Dec 6 1924, that I last saw her alive on Dec 6 1924, and that death occurred, on the date stated above, at 3-50 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Pulmonary Embolus (?)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wesbrook M. D.

, 19 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 12/10 1924

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baptist Parish Plate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1227 Harford Av St. 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna Tewes

(a) Residence No.... 1227 Harford Av St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Dr Wm Tewes

6-DATE OF BIRTH (month, day and year) Oct 21/33

7-AGE, 91 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Geo. F. Buckm...

(Address) 1227 Harford Av...

15-

Filed DEC 9 - 1924 ..... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/7/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1924 to Dec. 7 1924 that I last saw her alive on Dec. 7 1924 and that death occurred, on the date stated above, at 2.15 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Lee Magness M. D.

12 6 1924 (Address) 1206 E. Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Bults — DATE OF BURIAL, 12/10 1924

20-UNDERTAKER, Phil J. Herrg — ADDRESS 2016 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D A K

Spec.—1-10-21—M&T—1500 Bks.

Mamie Green

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92752

CERTIFICATE OF DEATH.

31 D 92752

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Druid ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Green

(a) RESIDENCE NO. 1129 Druid ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female colored Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lewis Gallaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Gertrude McMurry 1161 Druid Hill Ave

15 DEC 9 - 1924 Registered

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1924, to Dec 5, 1924, that I last saw her alive on Dec 4, 1924, and that death occurred, on the date stated above, at 10.50 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (one)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. N. Hatchett M. D.

Dec 5, 1924 (Address) 1111 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. W. Woodlawn Cem — DATE OF BURIAL 12-9-24

20 UNDERTAKER: David Carbon — ADDRESS 916 Eutaw

See Letter in file from Dr. Yankun dated 10-27-28

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 92753

CERTIFICATE OF DEATH

REGISTERED NO. D 92753

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Curley St.; 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME Elenora Sicha

(Residence in Baltimore: No. 407 N. Curley St.; 45 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow Married

6-DATE OF BIRTH: Wife of Thomas Sicha (Month) Jan 1 (Day) (Year)

7-AGE: 45 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Bohemia

PARENTS

10-NAME OF FATHER: Joseph Vojtis

11-BIRTHPLACE OF FATHER (State or country): Bohemia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Sicha

(Address) 407 N Curley St

15- Filed ..... 191 ..... Robert F. Kaufer, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 6th 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1924, to, Dec 6th 1924, that I saw h.r alive on Dec 6th 1924, and that death occurred, on the date stated above, at 11 30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs mos ds.

Contributory (SECONDARY) Cedema of Lungs

(Duration) yrs mos ds.

(Signed), M. D.

,191 [Address] 119 N. Milton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn

DATE OF BURIAL: Dec 10 191 24

20-UNDERTAKER: Frank Evert & Son

ADDRESS: 1906 Eastland Ave

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92754

D 92754

CERTIFICATE OF DEATH.

118,003

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 959 N. Chester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bartunek

(a) Residence No. 959 N. Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Bartunek

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS

10-NAME OF FATHER. Tobias Masopust

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant) Frank Bartunek

(Address) 959 N. Chester St.

15- Filed DEC 9 1924 Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 7/24

17- I HEREBY CERTIFY, That I attended deceased from DEC 5 1924 to DEC 7 1924

that I last saw her alive on DEC 7 1924

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

following Incarcerated

Obstruction

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Reysaver M. D.

(Address) 801 N. Kenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Hill — DATE OF BURIAL. Dec 10 1924

20-UNDERTAKER. Frank Erickson — ADDRESS 1806 Bland St

N. B.—FAMILY PHYSICIANS, WITH UNDERTAKERS, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92755

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 Fulton Ave St., 70 Ward) 76

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Cornelia Gibbs

(a) Residence No. Home for the aged of the M E Church St., Ward.
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 4, 1839

7-AGE. 86 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Harrison Gibbs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Roberts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-

(Informant) Ettie Leadley

(Address) 400 N Fulton Ave

15-

Filed DEC 9 - 1924 19.. Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 8/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 19 24 to Dec 8 19 24

that I last saw h. alive on Dec 6 19 24

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) 4 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Paresis

(Duration) ✓ yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) George G Shannon M. D

. 19 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount	Dec 10 1924
20-UNDERTAKER. George J Smith	ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1304 W Lombard St., 19 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Eliza Garrison Sweeny

(a) Residence No. 1304 W Lombard St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 4 1834

7-AGE, 90 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Geo F Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Esther Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) D F Sweeny

(Address) 213 W Paul St

15- Filed DEC 9 - 1924 ROBERT E. KNIGHT, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 9 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 5, 1924, to Dec 9, 1924, that I last saw h alive on Dec 5, 1924, and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Agnew M. D.

, 19 (Address) 101 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cem — DATE OF BURIAL, Dec 11, 1924

20-UNDERTAKER, George J Smith — ADDRESS 153 S Hollins St

WRITE PLAINLY, with UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—5M—R.S.—400 Bks.

D 92757.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92757.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 524 S. Dallas St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine. Szymkowiak

(a) Residence No. 524 S. Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 8 1922

7-AGE. 2 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph . Szymkowiak

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Catherine. Niec

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mr. Joseph. Szymkowiak

(Address) 524 S. Dallas Street

15- Filed ..... 192... Registrar.

DEC 9 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1924 to Dec. 7 1924

that I last saw h[illegible] alive on Dec. 3 1924

and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

~~1a~~ Mitral Stenosis &
Regurgitation

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) A. F. Rice per F.H.R. M. D.

, 19 (Address) 24 S. B'dway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem.	Dec. 9 1924
20-UNDERTAKER,	ADDRESS
John A Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Forsythe 422 E Lafayette

D 92758

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 92758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2218 Cecil Ave. (ST.) 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Martin

(a) RESIDENCE NO. 2218 Cecil ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Martin

6 DATE OF BIRTH (month, day and year): Mar 30-1882

7 AGE — Years: 42 — Months: 8 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm. Moloney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anastatia Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jos. Martin

(Address): 2218 Cecil Ave

15 Filed DEC 9 - 1924 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1924, to Dec. 7, 1924.

that I last saw h[illegible] alive on Dec. 7, 1924,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris,

Mild attacks in the

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) 10 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

12-9, 1924 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Cemetery — DATE OF BURIAL: 12/10 1924

20 UNDERTAKER: J. J. Moran — ADDRESS: 300 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Dr. Petitsien

D 92759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92759

CERTIFICATE OF DEATH.

817 Hamilton Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Dr. Royal ave ST., 11 WARD)

2-FULL NAME Catherine Desin

(a) RESIDENCE NO. 1323 Dr. Royal ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carmine Desin

6 DATE OF BIRTH (month, day, and year) Mar 24 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Bonsantini De Rosa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Matilda Assanta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rose Bassetgla
(Address) 1323 Dr. Royal ave

15 DEC 9 - 1924 ROBERT N. JACKTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1924, to Dec 7, 1924.

that I last saw h.r alive on Dec 7, 1924.

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Petitsien, M. D.

19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem.

DATE OF BURIAL: 12/10 1924

8 UNDERTAKER: J. F. Nolan

ADDRESS 300 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

92760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92760

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1900 W. Lexington St. 51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hushbeck Smalley

(a) Residence No. 1900 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Smalley

6-DATE OF BIRTH (month, day and year) May 1848

7-AGE, 76 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Whiteside

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mrs. Cherry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. Mamie Hood

(Address) 1900 W. Lexington St.

DEC 9 - 1924

Filed ... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 2, 1924, to Dec 7, 1924, that I last saw h. alive on Dec 6, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Abrasion Endocarditis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) J. M. Linthicum M. D.

12-8. 1924 (Address) 826 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL, Dec 9, 1924

20-UNDERTAKER: Joseph B. Cook ADDRESS 1003 N. Dallas

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 9276 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 9276

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 High Alley ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Curry

(a) RESIDENCE No 1225 High Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) June 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant J. W. Henderson
(Address) 1502 E. Monument St

15 Filed DEC 9 - 1924 ROBT. N. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonoa (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. M. Collen (Coroner.) M. D.

12/9/24, 192 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Dec 7 1924

20 UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

Strec—12-23-21—E.B.R.S.—400 Eks.

NATHAN BASS

D 92762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92762

CERTIFICATE OF DEATH.

3 74-801

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 28 S. Exeter St., 3 Ward) •

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Bass

(a) Residence No. 28 S. Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE.	If LESS than 1 day,
74 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) J. Levis

(Address) 1430 E. Balto. St.,

15- Filed [illegible] 192[illegible] ROBERT R. KRAUTER, Registrar.

DEC 9 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-9-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 19 24, to Dec 8 19 24

that I last saw h. alive on Dec 8 19 24

and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Chaver M. D.

, 19 (Address) 232 Med

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Herring Run	Dec 9, 19 24
20-UNDERTAKER.	ADDRESS
Jacob Levis	1434 E. Balto.

THIS IS A PERMANENT RECORD. EXPERT NEWS PRINTING. WRITE PLAINLY, WITH UNFADING INK—THIS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92763

CERTIFICATE OF DEATH.

161-001

D 92763

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 Bank ST., V WARD)

2-FULL NAME Baby Chamberlain

(a) RESIDENCE No. 2033 Bank ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. 7 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Premature Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Premature Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mildred Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): George Chamberlain 2033 Bank St

15 DEC 9 - 1924 ROBERT R. KRAMER, Registrar

Burial Permit Clerk

2029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/7 .1924. to 12/8 .1924.

that I last saw him alive on 12/7 .1924.

and that death occurred, on the date stated above, at 12.50 A.M.

The CAUSE OF DEATH* was as follows:

Premature Infant

24 Weeks Gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Samuel J. Fickes, M. D.

. 19 . (Address) 1126 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Dec 9 1924

20 UNDERTAKER: Commissioner Health,

Per Wm. E. WOODALL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92764

CERTIFICATE OF DEATH.

74-001

D 92764

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1231 Valley St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Terrence McMahon

(a) Residence No.... 1231 Valley St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie McMahon

6-DATE OF BIRTH (month, day and year) April 14-1845

7-AGE. 79 yrs. 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. James McMahon

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) John McSharry

(Address) 1231 Valley St

15- Burial Permit Issued DEC 9 - 1924 Dec 9 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/8/24

17- I HEREBY CERTIFY, That I attended deceased from 12/6, 1924, to 12/8, 1924, that I last saw h.. alive on 12/8, 1924, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 16 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? —— Date of .....

Was there an autopsy? —

What test confirmed diagnosis?.....

(Signed) Edward F. Mason, M. D.

12/8, 1924 (Address) The Emerson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral Cemetery	Dec. 10, 1924
20-UNDERTAKER.	**ADDRESS**
H. C. Friedfeld	914 Greenmount

Spec—12-23-21—E.B.R.S.—400 Eks.

Blum

D 92765 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92765

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 832 Brooks Lane St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hermie Blum

(a) Residence No. 832 Brooks Lane St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
60 yrs. — mos. — ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Solomon Blum

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sarah Hess

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Straus
(Address) 832 Brooks Lane.

15- DEC 9 - 1924 ROBERT S. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 8-24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1921 to Dec. 8 1924 that I last saw h[illegible] alive on Dec 8 1924 and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

chronic nephritis - myocarditis arterio-sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia -

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I. Frederick Lentz M. D.

12-8 1924 (Address) 7040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Oheb Shalom Cemetery	12/10/24 19....
20-UNDERTAKER, David Sandheim	ADDRESS 118 20 W. Mt. Royal Ave

Spec. 6-9-10—H. P. Co.—1000 Blks.

D 92766 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Mulberry St ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Schillinberg

(a) RESIDENCE. NO. 1208 N. Mulberry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 20 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Roy F Schillinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Clara Trekle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Roy F Schillinberg
(Address) Shepherd Pratt Hospital

15 Filed DEC 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1924, to Dec 7th, 1924, that I last saw her alive on Dec 7th, 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Intestinal intoxication

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W. R. Linden, M. D.

12/8. 1924 (Address) 3326 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Whitestone Va	Dec 10 1924
20 UNDERTAKER John O Mitchell	ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92767.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 92767

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3626 Maple Ave ST., 13 WARD)

2-FULL NAME Grafton Brooks

(a) RESIDENCE NO. 3626 Maple ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None — Job

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cockeysville Md

PARENTS

10 NAME OF FATHER John S Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John H Brooks Hampstead Md

15 Filed DEC 9 - 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9-1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1924, to Dec 9, 1924, that I last saw him alive on Dec 7, 1924, and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

(Pylorus Stenosis) Carcinoma

Known

(duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Senility + Arterio-Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic Symptoms

(Signed) C. B. Emerson, M. D.

12-9-1924 (Address) 5106 Park Ave Cor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hampstead Md — DATE OF BURIAL: Dec 11 1924

20 UNDERTAKER: C. V. Tipton & Son — ADDRESS: Hampstead Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92768

CERTIFICATE OF DEATH.

146

D 92768

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve A. Wagner

(a) RESIDENCE NO. University Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of George Wagner

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	-	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward J. Hanrahan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Ryan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George W. Wagner
(Address) University Apts.

15 DEC 9 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1924, to Dec 6, 1924, that I last saw h[illegible] alive on Dec. 6, 1924, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows: Incomplete Miscarriage

(over)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hirtonitis, Bacteremia

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas K. Galvin, M. D.

, 19 (Address) 335 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/10 1924

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92769

CERTIFICATE OF DEATH.

D 92769

51

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE; (No. 737 Hanover St. 23 Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Mary A. Baizell

(a) Residence No. 737 Hanover St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 8 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of August F.

6-DATE OF BIRTH (month, day and year) Mar 21 1874

7-AGE. 50 yrs. 8 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Robt. Lippard

11-BIRTHPLACE OF FATHER (City or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Tuttle

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Balto. Md.

14- (Informant) August Baizell (Address) 737 Hanover St.

15- Filed ..... Robert P. Harrison, Registrar.

EC9 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 7-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 19 24 to Dec 7 19 24

that I last saw h.. alive on Dec 7 19 24

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

.....

.....

.....(Duration)...yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

.....(Duration)...yrs. 1 mos. 17 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Michelle, M. D.

Dec 9. 1924 (Address) 127 Gilliam Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Pk.	Dec 10 1924
UNDERTAKER.	ADDRESS
Margaret E. Flynn	1101 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (NO. 7 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Chittum (John Sturgeon Chittum)

(a) RESIDENCE NO. 416 Edmonds St ST., WARD Clifton Forge, Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie May Chittum

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Loco Eng 0713

(b) General nature of industry, business, or establishment in which employed (or employer) C & O Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) Rockbridge (State or country) Virginia

PARENTS

10 NAME OF FATHER Zachariah Chittum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Clark

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Records HOSPITAL (Address)

15 Filed 29-1924 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9- 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 17 - , 1924, to Dec 9- , 1924,

that I last saw h~~e~~live on Dec 9- , 1924,

and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Penis - Recurrence

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? Yes Date of Oct. 29, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M H Goodman, M. D.

12-9-24 . 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clifton Forge. Va. DATE OF BURIAL Dec 9th 1924

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N Eutaw St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92771

CERTIFICATE OF DEATH.

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Harding Place ST., 13 WARD)

2-FULL NAME Baby Cook (Agnes May Cook)

(a) RESIDENCE NO. 606 Harding Place ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Lester B. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Shenandoah Co. Va.

12 MAIDEN NAME OF MOTHER Agnes M. Gerality

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Agnes M. Gerality (Address) 606 Harding Place

15 Filed 9 - 1924 16 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1924, to Dec. 9, 1924, that I last saw her alive on Dec. 8, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Congenital atelectasis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Mackin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
L. Manje Franklin	Dec 10 1924
20 UNDERTAKER Horace H. Burgee	ADDRESS 1231 Falls Rd

MARGIN RESERVED FOR BINDING.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92772 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1605 Hilton St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Fannie May Schanze.

(a) Residence No..... 1605 N.Hilton St. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Charles H.Schanze

6-DATE OF BIRTH (month, day and year) October 3.1874

7-AGE.	If LESS than 1 day.
50 yrs. 2 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Wm.T.Sagle,

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER, Fannie G.Davis,

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Baltimore Md.

14- (Informant) Charles H.Schanze.

(Address) 1605 N.Hilton St.

15- Filed DEC 9 - 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). DEC 8 1924

17- I HEREBY CERTIFY, That I attended deceased from July 8 1923 to Dec 8, 1924 that I last saw her alive on Dec 8, 1924 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary.

about 5 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Carcinomatosis

(Duration) yrs. 18 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 5 yrs

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard A. Warner, M. D.

DEC 9, 19 (Address) 757 Garrison Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge DATE OF BURIAL, DEC 11 1924 19

20-UNDERTAKER, Albert S. Little ADDRESS 2700 EDMONDSON AVE.

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92773

D 92773

CERTIFICATE OF DEATH.

REGISTERED NO. 76

1-PLACE OF DEATH (West Baltimore General Hospital

CITY OF BALTIMORE: (No. Regnor ave + Dukeland ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Patrick Lyons

(a) RESIDENCE NO. 115 N Lakewood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosella Lyon

6 DATE OF BIRTH (month, day, and year) Dec 12 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	45	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 990

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Michael Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kath Beers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs Mary Lyons 115 N Lakewood ave.

15 Filed DEC 9 - 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/5, 1924, to 12/7, 1924,

that I last saw him alive on 12/7, 1924,

and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

General Paresis.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 4 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Clement B. Moran, M. D.

19 (Address) West Baltimore General Hospital Regnor ave + Dukeland st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec 10 1924

20 UNDERTAKER J. G. Moran

ADDRESS 300 E Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92774

CERTIFICATE OF DEATH.

101-0012

D 92774

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12 WARD)

2-FULL NAME Mrs. Ellen Meadowcroft

(a) RESIDENCE NO. 408 N. Colvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jno R. Meadowcroft

6 DATE OF BIRTH (month, day, and year): Apr. 1871

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Bartholomew Edmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ellen M. Foley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. Edward Meadowcroft

15 Filed DEC 9 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/7/24

17 I HEREBY CERTIFY, That I attended deceased from 12/4/24, 19 to 12/7/24, 19, that I last saw h[illegible] alive on 12/6/24, 19, and that death occurred, on the date stated above, at 9:10 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer [illegible] — DATE OF BURIAL: 12/10/24

20 UNDERTAKER: J. A. Moran — ADDRESS: E. Baltimore

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and Undertakers CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92775

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-D 92775

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH West Baltimore Gineral Hospital

CITY OF BALTIMORE: (No. Raynor ave and Dukeland ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Ernest Morgan -

(a) RESIDENCE NO. 1416 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian B Morgan

6 DATE OF BIRTH (month, day, and year) Feby 22/1888

7 AGE 36 Years 10 Months 21 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor - 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington Co (State or country) Md.

PARENTS

10 NAME OF FATHER Noah Morgan

11 BIRTHPLACE OF FATHER (city or town) Washington Co (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Dipon

13 BIRTHPLACE OF MOTHER (city or town) Washington Co (State or country) Md

14 Informant Noah Morgan Jr (Address) 1401 Kuper Place

15 DEC 9 - 1924 Robert P. Harrison, , 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/21 , 1924 , to 12/8 , 1924 ,

that I last saw him alive on 12/8 , 1924 ,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia -

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilitation

(duration) yrs. mos. 6 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 12/2/24

Was there an autopsy? yes - (over)

What test confirmed diagnosis? Clinical + autopsy.

(Signed) Clement B. Monroe, M. D.

, 19 (Address) West Baltimore Gineral Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Dec 11 1924

20 UNDERTAKER Harry N Thomas — ADDRESS 4204 Ridgewood Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92776

CERTIFICATE OF DEATH.

124

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 N North Ave | 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Walton

(a) Residence No. 928 N North Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Addison Walton

6-DATE OF BIRTH (month, day and year) May 18th 1856

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Dallo City

PARENTS

10-NAME OF FATHER. John A. Offner

11-BIRTHPLACE (OF FATHER (city or town) (State or Country). Penna

12-MAIDEN NAME OF MOTHER Christina Dover

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Dallo City

14- (Informant) Thomas N Smith

(Address) 928 N North Ave

15- Filed DEC 9 - 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from July 8th 19 24 to Dec 8th 19 24

that I last saw h. alive on Dec 7th 19 24

and that death occurred, on the date stated above, at 9.10 a.m.

The CAUSE OF DEATH* was as follows:

Uremia Catarrhalis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (est confirmed diagnosis?

(Signed) Wm. H. Wiser M. D.

Dec 8 19 24 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park | DATE OF BURIAL. 12/10 19 24

20-UNDERTAKER, Cahn Graul & Co | ADDRESS 727 E Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92777

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1735 Aisquith St., 9 WARD)

2-FULL NAME Elizabeth Hoel-

(a) RESIDENCE NO. 1735 Aisquith St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian

6 DATE OF BIRTH (month, day, and year) Nov. 4 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Morris Strickel-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kate Brown

(Address) 1735 Aisquith St

15 Registrar

Robert P. Harrison,

Burial Permit Clerk.

DEC 9 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1- 24 to Dec. 9 1924.

that I last saw he alive on Dec 8 1924

and that death occurred, on the date stated above, at 1-30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. E. Turnbach M. D.

1924 (Address) 1531 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Sec.	11 1924
20 UNDERTAKER	ADDRESS
H. M. Cook	502 E. Fayette Ave.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92778

CERTIFICATE OF DEATH.

D 92778

REGISTERED NO. 161-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1210 Brentwood Ave. (St.) 10 (Ward)

2-FULL NAME John Paul Hoss

(a) RESIDENCE: (No.) 1210 Brentwood Ave. (Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX — 4 COLOR OR RACE: Male White — 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 29-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md.

PARENTS

10 NAME OF FATHER: John A. Hoss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Helen H. Nietzsichmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John A. Hoss 1210 Brentwood Ave.

15 DEC 9 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1924, to Dec 9, 1924, that I last saw h— alive on Dec 8, 1924, and that death occurred, on the date stated above, at 8—P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. S. Simkiewicz M. D.

Dec 9 1924 (Address) 2320 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 10 1924

20 UNDERTAKER: George L. Schmidt — ADDRESS: 1011 Fulton Ave.

Spec—12-23-21—E.B.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92779

D 92779

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH St. Joseph's Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 9 St., Ward)

2-FULL NAME Jennie Ball

(a) Residence No. St. Helena Md. St., Ward St. Helena Md. (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Samuel P. Ball

6-DATE OF BIRTH (month, day and year) 10/15/1884

7-AGE. 40 yrs. 1 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS:

10-NAME OF FATHER. James Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Samuel P. Ball (Address) St. Helena Md

15- Filed DEC 9 - 1924 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/7/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1924, to Dec. 7, 1924, that I last saw h.. alive on Dec. 6, 1924, and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Nephritis Complet

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. B Sybert M. D

19 (Address) St. J. H. Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Marys Hampden — DATE OF BURIAL. 12/10/24, 19...

20-UNDERTAKER. Geo. J. Ruth — ADDRESS 1131 Hanover Ave.

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. OCCUPATION is very important. Exact statement should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D 92780

CERTIFICATE OF DEATH.

1 D 92780

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME John Crowe

(a) RESIDENCE NO. Gettysburg, Pa ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 6 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work architect

(b) General nature of industry, business, or establishment in which employed (or employer) —"— 016

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER J. M. Crowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Ella Mae Comick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records JOHNS HOPKINS HOSPITAL (Address) Robert F. Hartigan,

15 DEC 9 - 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924, to Dec 9, 1924, that I last saw h— alive on Dec 9, 1924, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

3

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec 8 —

Was there an autopsy? Yes

What test confirmed diagnosis? Exam.

(Signed) Warfield M. Firor M. D.

19 (Address) J. C. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Pa. DATE OF BURIAL 12/9/24 19

20 UNDERTAKER H. C. Mumbaugh & Son ADDRESS Gettysburg Pa

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92781

D 92781

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 W.Hill St. ST., 22 WARD)

2-FULL NAME Thomas Bannister.(C)

(a) RESIDENCE NO. 138 W.Hill St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ---mos.--- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	---		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co.Md.

PARENTS

10 NAME OF FATHER Benjamin Bannister.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co.Md.

12 MAIDEN NAME OF MOTHER Mary J.Chase.(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co.Md.

14 Informant William H?Gant.(C) cousin.
(Address) 515 Dolphin St.

15 Filed DEC 10 1924 ROBT. R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 8,1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto H. Reinhardt, M. D.
(Coroner.)

Dec, 9, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery DATE OF BURIAL Dec 10 1924

20 UNDERTAKER John H. Toadvine ADDRESS 1027 Druid Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92782

CERTIFICATE OF DEATH.

45D 92782

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 S Eden St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Smith

(a) Residence No. 430 S Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-~~Single, Married~~, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Smith

6-DATE OF BIRTH (month, day and year) July 23 1866

7-AGE, 58 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 340
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Sebastian Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Charles D Courtney

(Address) 3[illegible] Eastern Ave

15- DEC 10 1924 CHAS. S. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 19 24 to Dec 8 19 24

that I last saw h[illegible] alive on Dec 8 19.....

and that death occurred, on the date stated above, at 10[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia,

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

19 24 (Address) 14 So Eden

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 11 1924
20-UNDERTAKER Wendell Coffeldon	ADDRESS 37 S Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92783

CERTIFICATE OF DEATH.

101-001 D 92783

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N. Luzerne ave. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Wilkinson

(a) RESIDENCE. No. 138 N. Luzerne St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May Wilkinson

6 DATE OF BIRTH (month, day, and year): July 27 1888

7 AGE: Years 36 Months 4 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James S. Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md

12 MAIDEN NAME OF MOTHER: Cath. Roach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Cath Wilkinson

(Address): 138 N. Luzerne

15 Filed . 19 ROBERT F. KRAUTER, Registrar

DEC 10 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6 1924 to Dec. 8 1924

that I last saw him alive on Dec 8 1924

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Pulmonary Odema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) # [illegible] M. D.

. 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Dec. 11 1924

20 UNDERTAKER: Jos J. Iler

ADDRESS: 156 N. Luzerne

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92784

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1220 W. North Ave. St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Jacob Brecourtz

(a) Residence No. 1220 W. North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
71 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Roumania

PARENTS.

10-NAME OF FATHER, Benj. Brecourtz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Roumania

12-MAIDEN NAME OF MOTHER, Crist —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Roumania

14- (Informant) Lewis

(Address) 1439 E. Balto. St.

15- Filed DEC 10 1924 N. KAUFER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-10-24

17- I HEREBY CERTIFY, That I attended deceased from December 1923 to December 1924

that I last saw him alive on December 9 1924

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical Signs

(Signed) Samuel Silverstein M. D.

, 19 (Address) 22 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	Dec 13 1924
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—10-31-Cl—M&T—1500 Bks.

Potter notified See Letter in file 2-10-1925 from A A Landsteiner MD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92785

CERTIFICATE OF DEATH.

101-00

D 92785

Heberw Hospital

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 6 WARD)

2-FULL NAME George Myer

(a) RESIDENCE NO. 447 W. Lakewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Widowed~~ (Married)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 53; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Myer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1739 E. Baltimore St

15 Filed DEC 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1924, to Dec 9, 1924, that I last saw him alive on Dec 9, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) A1 Lobar Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A. Stiller Landsteiner, M. D.

Dec, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Dec 10 1924

20 UNDERTAKER Jack Lewis 1739 E. Balto — ADDRESS

S·A·FETY

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92786

CERTIFICATE OF DEATH.

101-001 D 92786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clifton Jackson

(a) RESIDENCE No 1522 Ashland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 21/1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Guy Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edna Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edna Davis Jackson
(Address) 1522 Ashland Ave

15 Filed DEC 10 1924 ROBT. R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins (Coroner.) M. D.

Dec 9 24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn cemetery	Dec 10 1924
20 UNDERTAKER Edward Bryson	ADDRESS 631 Orleans

Information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92787

31 D 92787

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E Cross st. ST., 24 WARD)

2-FULL NAME Emma Mary Mathews

(a) RESIDENCE NO. 217 E Cross st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 1. 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	14	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

999

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hawkins Point Md.

12 MAIDEN NAME OF MOTHER Julia Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co Md

14 Informant Georgie Mathews

(Address) 217 E Cross St.

15 DEC 10 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 8, 1924, to Dec 9, 1924.

that I last saw her alive on Dec 8, 1924.

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 0 yrs. 11 mos 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 573 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Cem. Kent Co. Md.	Dec. 12, 1924
20 UNDERTAKER Chas. L. Pleasants	ADDRESS 1001 E Pratt St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 92788 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92788

1-PLACE OF DEATH Bayview Hospital

Registered No.

City of BALTIMORE: (No. 11 St., Ward)

(If death occurred in a hospital or institution, give Its NAME instead of street and number.)

2-FULL NAME Hattie Hill

(a) Residence No. 433 Rose Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Blk

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Griffin Hill

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Do

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Bayview Hospital

(Address) Bayview, Md.

15- Filed DEC 10 19.. ROBT. R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 7, 1924

I HEREBY CERTIFY, That I attended deceased from Nov. 23 19 24 Dec 7, 19 24

that I last saw h alive on Dec 7, 19 24

and that death occurred, on the date stated above, at 5-10 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Psychosis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. Fredonnett M. D.

12/8/24 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL, Dec 7 19 24

20-UNDERTAKER, Samuel D Hurley ADDRESS 111 Eddy St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92789

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Southern Hospital St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Walton

(a) Residence No. 3301 Abell Avenue St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Tiernan Walton

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. 72 yrs. — mos. — ds. If LESS than 1 day ...hrs. or...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Columbia
(State or Country) Mo.

PARENTS

10-NAME OF FATHER, Henry F. Garey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Gwynn Ball

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Kentucky

14- (Informant) Mrs. G.T.W. Banks
(Address) 3301 Abell Avenue

15-

Filed DEC 10 1924 ROBERT R. KRAUTER Registrar. Keith Perrin Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19 14 to Dec 9th 19 24

that I last saw h. Ex alive on Dec 7th 19 24

and that death occurred, on the date stated above, at 1.15A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
Right hemiplegia

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema a few hours

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Oscar B Sunkoss M. D

, 19 (Address) 1111 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cemetery	12/10 19 24
20-UNDERTAKER,	ADDRESS
Henry W. Sears & Son	805 N. Calvert

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 92790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 92790

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3316 Piedmont Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Kain

(a) Residence No. 3316 Piedmont Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 11 mos. 30 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Dec. 9, 1894

7-AGE.	If LESS than 1 day.
29 yrs. 11 mos. 30 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Cochran Hill

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER. Robert Kain

11-BIRTHPLACE OF FATHER (city or town) Martinsburg
(State or Country). West Virginia

12-MAIDEN NAME OF MOTHER, Mary F. Stanton

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country). Maryland

14- (Informant) Mrs. Mary F. Kain

(Address) 3316 Piedmont Avenue

15- Filed DEC 10 1924 ROBT. R. KRAUTH
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1924 to Dec 8 1924

that I last saw him alive on Dec 7 1924

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Edw. Lockwood M. D

12/9 1924 (Address) 1358 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	12/ 1924

20-UNDERTAKER.	ADDRESS
Henry W. Spears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-2 (E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92791

CERTIFICATE OF DEATH.

D 92791

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 529 S. Rose St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Eck

(a) Residence No. 529 S. Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 97 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Widow

6-If ~~married~~, widowed, or ~~divorced~~ (HUSBAND of) (WIFE of) Henry Eck

6-DATE OF BIRTH (month, day and year) June 16-1828

7-AGE. 96 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS

10-NAME OF FATHER. Adolf Kaufman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Adolf Kaufman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Mary Schneidemann

(Address) 529 S. Rose St.

15- DEC 10 1924 ROBERT S. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8 19 24 to Dec. 9 19 24

that I last saw h[illegible] alive on Dec. 9 19 24

and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard Kemperth M. D

19 (Address) 2829 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Dec 11, 1924
20-UNDERTAKER.	ADDRESS
Wm. Cook & Son	2 E Lexington

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Franck Glowacka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92792

D 92792

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Curley ST., 1 WARD)

2-FULL NAME Franck B. Glowacka

(a) RESIDENCE No. 619 S. Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph

6 DATE OF BIRTH (month, day, and year): Aug 29 1869

7 AGE: Years 55 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mrs Glowacka (Address): 619 S. Curley

15 Filed ..... 19..... ROBERT N. KRAUTER, Registrar

DEC 10 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924, to Dec 9, 1924, that I last saw her alive on Dec 8, 1924, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb R. Stiles, M. D.

Dec 9, 1924 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec. 12 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 1002 E Pratt

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92793

CERTIFICATE OF DEATH.

90 D 92793

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 828 George St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Ella Hester

(a) Residence No. 828 George St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed or divorced WIFE of Aaron Hester

6-DATE OF BIRTH (month, day and year) Mar. 15 1865

7-AGE 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER Peter Blotzer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Annie Watson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Aaron Hester

(Address) 828 George St.

15-

Filed DEC 10 1924 [illegible] Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 7/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1924 to Dec 6, 1924 that I last saw h[illegible] alive on Dec 1924 and that death occurred, on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

Mitral disease heart

(Duration) yrs. mos. ds.

CONTRIBUTORY — (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

12 (Signed) [illegible] M. D.

Dec 1924 (Address) 1176 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL, Dec 10, 1924

20-UNDERTAKER Mrs R. E. Elliott — ADDRESS 1125 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 92794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

#6 D 92794

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643 Darley Ave ST., 9 WARD)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. 1643 Darley Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of ~~(or)~~ WIFE of Jacob P. Williams

6 DATE OF BIRTH (month, day, and year) November 20 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	63	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of Industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Etzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs. Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ...

14 Informant Wm. Clarence P. Williams

(Address) 1643 Darley Ave

15 Filed DEC 10 1924 By ROBERT B. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept ..., 1924, to Dec 10, 1924, that I last saw her alive on Dec 9, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. Kuhn M.D.

12/10, 1924 (Address) 2700 Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 12 1924
20 UNDERTAKER	ADDRESS
Henry Houck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Walmsley ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92795

CERTIFICATE OF DEATH.

38 D 92795

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 19 WARD)

2-FULL NAME John B. Walmsley

(a) RESIDENCE NO. 1812 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeannette E.

6 DATE OF BIRTH (month, day, and year) April 22 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co., Md.

PARENTS

10 NAME OF FATHER James Walmsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co., Md

12 MAIDEN NAME OF MOTHER Jeannette E. Bunard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co., Md

14 Informant Jeannette E. Walmsley

(Address) 1812 McHenry st

15 Filed DEC 10 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-28 1924 to 12-8 1924

that I last saw him alive on 12-8 1924

and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

C.N.S Syphilis (General Paresis)

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Bruce M. D.

12-8 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall	Dec 11 1924
20 UNDERTAKER Gerkler & Zickler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WHEN PRESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Thompson

(a) Residence No. Fork Baltimore Co. Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): Dec 4, 1924

7-AGE: ..... yrs. ..... mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS:

10-NAME OF FATHER: Charles Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Emma Rugh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

11- (Informant): Chas. S. Thompson

(Address): Fork, Md.

DEC 10 1924

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 8, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1924, to Dec 8th, 1924, that I last saw her alive on Dec 8th, 1924, and that death occurred, on the date stated above, at 6.25 A m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Increased intra cranial pressure (Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Dudley P. Bowie M. D

, 19 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec. 10, 1924
20-UNDERTAKER	ADDRESS
George L. Lohmeyer	110 Cook Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92797

CERTIFICATE OF DEATH.

71-001 D 92797.

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Johns Hopkins hospital ST.. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alene Woods

(a) RESIDENCE No 1649 E. Abbottston St. ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) -----

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ba. to Md

PARENTS

10 NAME OF FATHER John Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Alene -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Johns Hopkins Hospital
(Address) JOHNS

15 Filed ....., 192.. [illegible] S. KRAUTER Registrar
Burial Permit Clerk.

DEC 10 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Purulent Meningitis

Pneumococcus (Autopsy at Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Wallis, M. D.
(Coroner.)

12/6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL Dec 9 192 4

20 UNDERTAKER [illegible] Commissioner Health, — ADDRESS

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92798

CERTIFICATE OF DEATH.

101-001

D 92798

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 S. Wolfe St. St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edward G. Aldewurtel

(a) Residence No.. 14 S. Wolfe St. St., 2 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Aldewurtel

6-DATE OF BIRTH (month, day and year) Dec 15-1850

7-AGE. 73 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Mark Aldewurtel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-Informant..... Agnes Aldewurtel

Address..... 14 S. Wolfe St.

15-Filed DEC 10 1924 ROBERT R. KRAMER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 8-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1924, to Dec 8th, 1924, that I last saw h.. alive on Dec 8th, 1924 and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? ....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) I. Bullen Gilmore, M. D.

May 6th, 1925 (Address) 1900 Eastern Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL, Dec. 12th, 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92799

CERTIFICATE OF DEATH.

90 D 92799

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 706 S. Wolfe St. St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Julius Gebhardt

(a) Residence No. 706 S. Wolfe St. St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Gebhardt.

6-DATE OF BIRTH (month, day and year) April 23-1852

7-AGE, 72 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER Frderick Gebhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Mais —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mary E. Gebhardt

(Address) 706 S. Wolfe St.

15- Filed DEC 10 1924 19.. ROBERT S. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1923 to Dec 7 1924

that I last saw him alive on Dec 7 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease 12

(Duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Dr. Hickman M. D.

12/8 1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL, Dec. 10 1924

20-UNDERTAKER, Tilly & Zeller ADDRESS 403 S. Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 92800

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

2-FULL NAME Lucy McCardell

(a) RESIDENCE No. 638 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER James Fowler

11 BIRTHPLACE OF FATHER (city or town) Delaware (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Delaware (State or country)

14 Informant Municipal Hospital Records (Address)

Filed DEC 10 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-6 1924, to 12-7 1924.

that I last saw her alive on 12-7 1924

and that death occurred, on the date stated above, at 8.05 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude S. Dixon, M. D.

12-7 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem., Aaco.	Dec 10 1924
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St

Spec.—1-10-21—M&T—1500 Blks.

Ellen S. Clark

D 92801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 92801

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 W Lafayette ave ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen S Clark

(a) RESIDENCE No. 135 W Lafayette ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 26 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER Wm B Clark

11 BIRTHPLACE OF FATHER (city or town) Talbot Co (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia J Stiles

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Hester Dorsey

(Address) 133 W Lafayette ave

15 Filed DEC 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1924, to Dec 9 1924,

that I last saw her alive on Dec 8th 1924,

and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Right Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) General Debility, Anaemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of Resid

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) J Rawlins Price, M. D.

, 19 (Address) Glyndon Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Md	Dec 11 1924
20 UNDERTAKER Henry W Jenkins Sons	ADDRESS McCulloh & Orchard Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92802

CERTIFICATE OF DEATH.

15 101-001

D 92802

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3701 Kate Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James D. Jones

(a) Residence No. 3701 Kate Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

~~Single~~ ~~Married~~ ~~or Divorced~~ Widowed, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah G. Jones

6-DATE OF BIRTH (month, day and year) 1/25/1848

7-AGE, 74 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Dont Know.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Dont Know

14- (Informant) Mrs. Chas. Sigmund

(Address) 3701 Kate Ave

DEC 10 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/8/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 8, 1924, that I last saw him alive on Dec 7, 1924, and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (Duration) 1 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Jeans, M. D.

12/9, 1924 (Address) 3401 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Dec 10 1924
20-UNDERTAKER. John Reese	ADDRESS 208 Orleans

IMPORTANT—WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92803

CERTIFICATE OF DEATH.

3 D 92803

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St. St. Joseph's Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Marsiglea

(a) Residence No. 113 W. Pearl St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Jan. 5, 1906

7-AGE. 17 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): O & S

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS

10-NAME OF FATHER: Rosario Marsiglea

11-BIRTHPLACE OF FATHER (city or town) Italy (State or Country)

12-MAIDEN NAME OF MOTHER: Rosaria Liberto

13-BIRTHPLACE OF MOTHER (city or town) Italy (State or Country)

14- (Informant) Rosario Marsiglea

(Address) 113 W. Pearl St

15- Filed ..... 192.... DEC 10 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 7, 1924 to Dec 9, 1924 that I last saw h. alive on Dec 8, 1924 and that death occurred, on the date stated above, at 1.30 A. m. The CAUSE OF DEATH* was as follows:

Aortitis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Sybert M. D

, 19 (Address) St Jos. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemtry — DATE OF BURIAL: 12/11/24

20-UNDERTAKER: George J. Ruth — ADDRESS: 1735 Hanford Av

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92804

CERTIFICATE OF DEATH.

10

D 92804

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 77 WARD)

2-FULL NAME Addie Hanson

(a) RESIDENCE No. 217 W. Hill St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Hanson

(Address) 217 W Hill St

15 Filed DEC 10 1924 ROBERT S. KRAUTER, Burial Permit Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1924, to Dec 9, 1924, that I last saw h[illegible] alive on Dec 9, 1924, and that death occurred, on the date stated above, at 9.15 p m.

The CAUSE OF DEATH* was as follows:

Diphtheria.

Tonsillar, Pharyn & Laryngeal

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of 12-9-24

Was there an autopsy? No

What test confirmed diagnosis? Pos. Diphtheria Culture

(Signed) Myron S. Tull, M. D.

12/10 1924 (Address) Sydenham Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel St — DATE OF BURIAL Dec 10 1924

20 UNDERTAKER H. E. Brown & Son — ADDRESS 108 N Mar[illegible]

N.B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25 179

D 92805

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Callahan

(a) Residence No. St Agnes Hospital St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ? 1854

7-AGE: 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): " "

12-MAIDEN NAME OF MOTHER: " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14- (Informant) St Agnes Hospt
(Address)

15- Filed ..... Robert E. Harrison, Registrar.

DEC 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/9/24

17- I HEREBY CERTIFY, That I attended deceased from March 21 st 1923 to Dec. 9th 1924
that I last saw him alive on Dec 8th 1924
and that death occurred, on the date stated above, at 7.20 p.m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis & Chr
Interstitial nephritis with
general arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. O'Meara M. D
, 19 (Address) St Agnes Hospl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral	Dec 11 19 24
20-UNDERTAKER.	ADDRESS
Martin Fuhrer & Son	1823 W North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1669
92806

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Kegedes

(a) RESIDENCE NO. Leechburg Pa ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) (Un/Known) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungaria

PARENTS
10 NAME OF FATHER George Kegedes
11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria
12 MAIDEN NAME OF MOTHER Bessie Gyrise
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant
(Address) JOHNS HOPKINS HOSPITAL.

15 DEC 10 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 9, 1924, that I last saw him alive on Dec 9, 1924, and that death occurred, on the date stated above, at 9 13 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. Several mos. ds.

18 Where was disease contracted if not at place of death? Pa.

Did an operation precede death? yes Date of 12/6/24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Cait H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leechburg Pa	12/10 1924
20 UNDERTAKER	ADDRESS
E I Fanning & Son, 1938 E Lafayette	

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Elizabeth's Home
City of BALTIMORE: (No. Chesnut Hill Ave St., 9 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen McGowen (relig. name Sister Mary Raymund)

(a) Residence No. St. Elizabeth's Home St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 19, 1860

7-AGE, 64 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Religious
(b) General nature of industry, business, or establishment in which employed (or employer) Nun
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-
(Informant) Mother Leonard
(Address) St. Elizabeth Home

15-
Filed DEC 10 1924, 192
Robert P. Harrison
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). December 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from May, 1924, to December 9, 1924, that I last saw h.e alive on December 9, 1924, and that death occurred, on the date stated above, at 4.15 P.m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Dec 10, 1924 (Address) 2028 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Elizabeth Home Grounds	Dec 12, 1924

20-UNDERTAKER.	ADDRESS
George H. Jenkins Co.	Orchard & Mulberry Sts

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92808

74 D 92808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 W. Franklin ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. H. Kuchman

(a) RESIDENCE NO. 1135 W. Franklin ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kuchman

6 DATE OF BIRTH (month, day, and year) Aug. 25, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Piano Polisher
(b) General nature of industry, business, or establishment in which employed (or employer) self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry E. Kuchman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Chas. H. Kuchman
(Address) 1135 W. Franklin

15 Filed DEC 10 1924, 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 10, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 12th 1924

20 UNDERTAKER E. Schlosman & Son

ADDRESS 1534 Hanover St

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92809

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST., 14 WARD)

2-FULL NAME Ellen Jackson

(a) RESIDENCE NO. Aged men & women's home ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate aged

(b) General nature of industry, business, or establishment in which employed (or employer) Men's Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Meredith Hardesty
(Address) 1509 N. Ballard St

15 Filed DEC 11 1924 ROBERT R. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9. 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1924, to Dec 9, 1924, that I last saw her alive on Dec 9 - 1924, and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows: A

Multiple Progressive muscular atrophy

(duration) yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J. Wheatley, M. D.

12/9, 1924 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	12-12, 1924
20 UNDERTAKER John H. Troden	ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92810 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 92810

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hon Russell St., 21 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dilgleman

(a) Residence No. 1101 Russell St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Col.

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Solen Dilgleman

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

070

9-BIRTHPLACE (city or town) (State or Country), md.

PARENTS.

10-NAME OF FATHER, Geo. Dobson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md.

14- (Informant) Eliza Mercer

(Address) Centreville, md.

15- Filed ..... 192.. M. ..... Registrar.

DEC 11 1924 R. J. S. KRANTZ

Burial Permit Issued

In plain terms, so that it may be properly classified. Exact statements should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH instructions on back of certificates. OCCUPATION is very important. See

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/8/24

17- I HEREBY CERTIFY, That I attended deceased from 11/21/24 to 12/8/24

that I last saw h... alive on 12/8/24

and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. 4 mos. ..... ds.,

CONTRIBUTORY (Secondary) Arteriosclerosis

Syphilis unknown (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Enos Cox M. D.

12/11, 1924 (Address) 908 N Shaffer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL, Dec. 11, 1924

20-UNDERTAKER, John H. Toadvine ADDRESS 1027 Druid Hill Ave

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92811

CERTIFICATE OF DEATH.

179

D 92811

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5325 Hamlin Ave (Rear) St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E. Baker

(a) Residence No. 5325 Hamlin Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. B.

6-DATE OF BIRTH (month, day and year) Sept 13 49

7-AGE. 75 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Jacob Keith

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Pa.

14- (Informant) Hiram L Gardner

(Address) 5325 Hamlin Ave

15- Filed..... 192.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 9. 24

17- I HEREBY CERTIFY, That I attended deceased from July 30 1924 to Dec 9 1924

That I last saw h.. alive on Dec 8 1924

and that death occurred, on the date stated above, at 2.30a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 1 yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon M. D

12/9, 1924 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Edmondson Md

DATE OF BURIAL. Dec 11. 1924

20-UNDERTAKER, W M Routson

ADDRESS 2238 W North

Social Service Dept.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 92812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2435 Madison Ave ST., 13 WARD)

2-FULL NAME Daniel Boughner

(a) RESIDENCE NO. 2435 Madison Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Mary Nicholson Boughner

6 DATE OF BIRTH (month, day, and year): June 25th 1854

7 AGE: Years 70 | Months 5 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Accountant

(b) General nature of industry, business, or establishment in which employed (or employer): Accounting Dept

(c) Name of employer: B. & O R R

9 BIRTHPLACE (city or town) (State or country): Greensboro Penna

PARENTS

10 NAME OF FATHER: Wm Boughner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greensboro Penna

12 MAIDEN NAME OF MOTHER: Louisa Milnor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greensboro Pa.

14 Informant: Mrs Daniel Boughner

(Address): 2435 Madison Ave

15 Filed DEC 11 1924 19 ROBERT S. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/9/ 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 9, 1924,

that I last saw him alive on Dec 9, 1924,

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 yrs. 2 mos 6 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilation

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) W. H. Cole, M. D.

, 19 (Address) 826 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greensboro Greene Co Pa

DATE OF BURIAL: Dec 11 1924

20 UNDERTAKER: Henry Watkins & Son Co

ADDRESS: Orchard & McCulloh Sts

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92813

CERTIFICATE OF DEATH.

16

904 D 92813

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1817 West Fayrale St., Ward)

2-FULL NAME. Frederick H Volker

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1817 West Fayrale St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of the late Carrie Volker

6-DATE OF BIRTH (month, day and year) Aug 25th 1859

7-AGE. 65 yrs. 3 mos. 13 ds. Or LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer). Self 088

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Herbert Volker

(Address) 1223 Oakhurst Ave

15- Filed DEC 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15th 1924 to Dec 8th 1924

that I last saw him alive on Dec 5th 1924

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Arteriosclerosis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Phy. + Lab. diagnosis

(Signed) A B Culbertson M. D.

12/9 1924 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. 12/11/24

20-UNDERTAKER. Gu Weber & Son — ADDRESS 2503 Edmondson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92814
1-PLACE OF DEATH

Registered No. D 92814

City of BALTIMORE: (No. 507 N. Collington Ave., 7 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Hess.

(a) Residence No. 507 N. Collington Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Hess

6-DATE OF BIRTH (month, day and year): Aug. 20, 1834

7-AGE: 80 yrs. 3 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Austria

PARENTS.

10-NAME OF FATHER: John Piemeisel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Austria

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14- (Informant) Mrs. R. F. Coggins
(Address) 507 N Collington Ave

15- Filed DEC 1 1924, 19?? ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 8. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 24 to Dec 8 19 24
that I last saw h[illegible] alive on Dec 8 19 24
and that death occurred, on the date stated above, at 6.10 P. m.
The CAUSE OF DEATH* was as follows:

Vas. Hirst Decem

(Duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmony Congestion

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank Illmyer M. D.
, 19 (Address) 1500 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Trinity Cemetery	Dec 10 1924
20-UNDERTAKER.	ADDRESS
H. Sander's Sons	1710 Fleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92815

CERTIFICATE OF DEATH.

129 D 92815

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 S. Streeper St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wilhelmina Moritz

(a) Residence No. 514 S. Streeper St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Gottfried Moritz

6-DATE OF BIRTH (month, day and year): Sept 12. 1838

7-AGE. 86 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:
10-NAME OF FATHER: Not known
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12-MAIDEN NAME OF MOTHER: Not known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14- (Informant) Robert F. Moritz
(Address) 514 S. Streeper St

15- Filed DEC 11 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 10/24

17- I HEREBY CERTIFY, That I attended deceased from June 20th 1924 to Dec 10th 1924, that I last saw h[illegible] alive on Dec 9th 1924, and that death occurred, on the date stated above, at 5 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Senile Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 10. 1924 (Address) 1900 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: Dec 13 1924

20-UNDERTAKER: H. Sander & Sons — ADDRESS: 1110 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92816

CERTIFICATE OF DEATH.

129

Registered No. D 92816

1-PLACE OF DEATH

City of BALTIMORE: (No. Carnegie & Duluth Aves St., 26 Ward) Graceland Park

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie E. Smith

(a) Residence No. Carnegie & Duluth Aves St., Ward
(Usual place of abode) Graceland Park (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 3 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Smith

6-DATE OF BIRTH (month, day and year) March 8, 1893

7-AGE. 31 yrs. 3 mos. 9 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Ah Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.
10-NAME OF FATHER, Charles J. Heines
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Carrie J. Frazier
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ft. Louise

14- (Informant) Frederick Smith
(Address) Carnegie Ave & Duluth Graceland Park

15- Filed DEC 11 1924 192. H. VICTOR KRAUTER Registrar. Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). December 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from DEC 1 1924 to DEC 9 1924
that I last saw h[illegible] alive on DEC 9 1924
and that death occurred, on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Chronic Paranephromatous Nephritis

(Duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension Cerebrosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Autumn
Did an operation precede death? No Date of No
Was there an autopsy? No
What test confirmed diagnosis? Chemical

(Signed) Dr Schreiber M. D.
12/10 1924 (Address) 330 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Dec. 12 1924
20-UNDERTAKER.	ADDRESS
H. Sander & Sons	1710 Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

ADAM. F. WESOLOWSKI

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92817

CERTIFICATE OF DEATH.

31 D 92817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Hudson ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam F. Wesolowski

(a) RESIDENCE No. 2625 Hudson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 25-1892.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook.
(b) General nature of industry, business, or establishment in which employed (or employer) ?
(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walenty Wesolowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Michaline Nowak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michaline Wesolowski.
(Address) 2625 Hudson St.

15 Filed DEC 1 1924, 192... HARRY R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) H. C. Hoke M. D.

12/10/24 142 (Address) 1378 Bway (Coroner.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem	Dec. 12, 1924.
20 UNDERTAKER M. J. Sadowski	ADDRESS 705 S. Ann

If LESS than 1 day, give hours or minutes. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Eks.

D 92818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Moore

(a) RESIDENCE No 1411 W. Lafayette Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Moore

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer @t home

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md

PARENTS

10 NAME OF FATHER Sam Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Woodland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Moore
(Address) 1411 W. Lafayette

15 Filed DEC 1 1924 192 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 /24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Autopsy at Hopkins Hospital)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S H Waller, M. D.
(Coroner.)
12/19/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peter's Cem Ave — DATE OF BURIAL Dec 11 1924

20 UNDERTAKER Joseph a Farrell — ADDRESS 2319 Division St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92819

CERTIFICATE OF DEATH.

179 D 92819

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.) No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Coldwell.

(a) RESIDENCE NO. 104 S. 8th. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Mrs May Engelhardt
(Address) 104 S 8th St

15 Filed DEC 1 1924 1924 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows: Accident Scalds.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac Nephritis (Duration) yrs. mos. ds.

(Signed) G. C. Yeides, M. D.
(Coroner)
Dec 10 1924 (Address) 43 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Dec 11 1924

20 UNDERTAKER John Ellrich

ADDRESS 2008 Orleans

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

92820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92820

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1006 Reach al St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Armes

(a) Residence No. 1006 Reach al St., 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Armes.

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mary Sample

(Address) 816 Chanal St.

15- Filed DEC 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/8/24

17- I HEREBY CERTIFY, That I attended deceased from 10/2/24, 19 to 12/8/24, 19

that I last saw h alive on 12/5/24, 19

and that death occurred, on the date stated above, at 8:30 PM.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Acute (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Gall Stones - Hepatic Congestion Acute (Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Lan Conley, M. D.

12/9/24 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Int Eastern Cem. DATE OF BURIAL, See 12 24, 19

20-UNDERTAKER, Chas Geo Hoffa ADDRESS 406 W. Conway St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

COPY

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92821

CERTIFICATE OF DEATH.

185 D 92821

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 825 N. Schutter St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Dubchak

(a) Residence No. 825 N. Schutter St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) Jan 4 1852

7-AGE.	If LESS than 1 day,
72 yrs. 0 mos. 0 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): NO

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS:

10-NAME OF FATHER, George Dubchak

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14- (Informant) Mr. George Shimek

(Address) 825 N. Schutter St.

15- Filed DEC 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. 20m.

16-DATE OF DEATH (month, day and year) Dec 9/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 7 1924 to Dec 9 1924

That I last saw her alive on Dec. 9 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Fracture Surgical neck of Right Humerus accidental

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Cooke M. D.

, 19 (Address) 845 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Hill	Dec. 12, 1924
20-UNDERTAKER.	ADDRESS
August Basek	921 North Glover St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92822

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 528 St Marys St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James A. Groome

(a) Residence No. 528 St Marys St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Marcella Groome

6-DATE OF BIRTH (month, day and year) 9-22-1854

7-AGE. 70 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Nathan Groome

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER. Elizabeth Dr[illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Marcella Groome

(Address) 528 St Marys St

15- Filed DEC 1 1924, 19.. ROBERT S. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 10, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923 to Dec 10, 1924, that I last saw h[illegible] alive on Dec 9, 1924 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? urinary

(Signed) J. S. McRae M. D.

12-10, 1924 (Address) 1126 Druid Hill

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. [illegible] DATE OF BURIAL Dec 13, 1924

20-UNDERTAKER. [illegible] ADDRESS [illegible]

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92823

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 92823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thos Ermer -

(a) RESIDENCE NO. 917 Harrison Alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time ds. How long in U. S., if of foreign birth? Life time ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year) Aug 8-1923

7 AGE: Years 1 Months 4 Days 1 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm. Ermer -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Ethel Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant University Hospital Records (Address)

15 Filed DEC 11 1924 19 JOHN R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-8 .1924. to 12-9 .1924

that I last saw him alive on 12-9 .1924

and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Empyema -

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 12-8-24

Was there an autopsy? —

What test confirmed diagnosis? Thoracotomy -

(Signed) M Lawrence M. D.

12/9 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: 12/11 1924

UNDERTAKER: William Gallowsky ADDRESS: 1618 Eastern Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92824

1-PLACE OF DEATH

Registered No.

City of BALTIMORE. (No. 644 Haw St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John J. Strickland

(a) Residence No. 644 Haw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Strickland

6-DATE OF BIRTH (month, day and year) Jan 7th 1868

7-AGE, 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lab. Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Plant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Strickland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Beatrice House

(Address) 207 N. Amity

15- Filed DEC 11 1924 Robert R. Kraster, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/8/24

17- I HEREBY CERTIFY, That I attended deceased from 12/5, 1924 to 12/8, 1924

that I last saw h in alive on 12/8, 1924

and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis.

Chr. Interstitial Nephritis about

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

12/9, 1924 (Address) 908 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Ant Brook Cem

DATE OF BURIAL, Dec 12 1924

20-UNDERTAKER. Bond East Bmore

ADDRESS 916

Instructions to Physicians and Undertakers. Every question must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92825

CERTIFICATE OF DEATH.

D 92825

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 17 WARD)

2-FULL NAME Earl Brooks

(a) RESIDENCE NO. 724 Bradley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	none

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Carroll Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ---- Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hopkins Hospital
(Address)

15 Filed DEC 1 1924 192 [illegible] Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobular Pneumonia

(Autopsy at Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Phelan, M. D.
(Coroner.)

12/10/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W W Cemetery Co	12-12-24
20 UNDERTAKER Frank D Easton - Co	ADDRESS 916

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Time of burial of female

D 92826 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 19 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Kelly Clements

(a) RESIDENCE NO. 568 Fairmount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 37
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Scott Lamar

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md Tenn

12 MAIDEN NAME OF MOTHER Jane Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md Tenn

14 Informant ..... Jane Coleman Jr.
(Address) 570 Granby St

15 Filed ..... 192 ..... Registrar

DEC 11 1924 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on entire body

(duration) 1 yrs. ..... mos. 2 days.

CONTRIBUTORY (Secondary) Accidental Ignition of clothing (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

12-11, 192 4 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn — DATE OF BURIAL 12-12-24

20 UNDERTAKER David Eurton ADDRESS 946 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92827

CERTIFICATE OF DEATH.

49 D 92827

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2033 E Biddle (St.) 8 (Ward)

2-FULL NAME John J Kammer

(a) RESIDENCE No. 2033 E Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Jennie Kammer

6 DATE OF BIRTH (month, day, and year) July 17 1873

7 AGE Years 51 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Kammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Wolff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Jennie Kammer

(Address) 2033 E Biddle St

15 Filed DEC 1 1924, 19.... Robert R. Kracke, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1923, to Dec 7th, 1924, that I last saw h alive on Dec 7th, 1924, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat

(duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) H. J. Faulkner, M. D.

, 19 (Address) 119 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 13 1924

20 UNDERTAKER Ralph J Smart Inc

ADDRESS N. Ave

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92828

CERTIFICATE OF DEATH.

129

D 92828

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 20 x 2 Gough (ST.) 2 (WARD)

2-FULL NAME James J Vain

(a) RESIDENCE NO. 20 x 2 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sate Ella A Vain

6 DATE OF BIRTH (month, day, and year) March 7 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Chas W Vain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Sarah Nesbit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant John A Beltz
(Address) 2027 Gough St

15 Filed ..... 19 ..... Registrar

DEC 1 1924 ROBT. B. KRAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 25, 1922, to Dec 8, 1924, that I last saw him alive on Dec 8, 1924, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examine

(Signed) D Arnold M. D.

, 19 (Address) 301 Sellwood Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 11 1924
20 UNDERTAKER J Robt Turner Son	ADDRESS 1138 Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92829

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

144

D 92829

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Gen'l Hosp St.) 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Naomi Winters Armstrong

(a) RESIDENCE No. 3246 Abel Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~: Percy Armstrong

6 DATE OF BIRTH (month, day, and year): May 31 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Samuel Winters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md.

12 MAIDEN NAME OF MOTHER: Louisa Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md.

14 Informant: Percy Armstrong

(Address): 3246 Abel Ave St.

15 Filed DEC 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1924, to Dec 10, 1924, that I last saw h alive on Dec 10, 1924, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary): Post Partum Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Delivery Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) William Lynch, M. D.

Dec 10. 1924 (Address) 1701 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 12/12 1924

20 UNDERTAKER: Chas McCully — ADDRESS: 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 92830 CERTIFICATE OF DEATH. 129 D 92830

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Lagnor ave & Dukeland ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Duff

(a) RESIDENCE No. 241 W Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 49	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work cook. 071

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Duff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Josephine Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant William Duff - deceased.
(Address)

15 Filed DEC 11 1924 HOWARD B. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/12, 1924, to 12/7, 1924, that I last saw h[illegible] alive on 12/7, 1924, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Endocarditis
Chronic nephritis about
(duration) 2 or 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation.
(duration) yrs. mos. 12 hrs

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clement A Rogers Laboratory

(Signed) Clement R Monat, M. D.

, 19 (Address) West Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY.
Undertaker Commissioner of Health,
Per. Wm. E. WOODALL

DATE OF BURIAL
DIRECT
DEC 11 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

376

Spec.—1-10-21 MAT 1500 Blks.

D 92831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 92831

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 N. Willow Ave ST., 8 WARD)

2-FULL NAME Elizabeth L. Reinfelder

(a) RESIDENCE NO. 1833 N Willow Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? Born yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Sing'l.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 5th 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	8	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER George Reinfelder

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Rohrmeier

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. George Reinfelder
(Address) 1833 N. Willow Ave

15 Filed DEC 7 1924 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5 , 19 24 , to Dec. 11 , 19 24 .

that I last saw h[illegible] alive on Dec. 11 , 19 24 ,

and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Wagner M. D.

13th, 19 24 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 13 1924
20 UNDERTAKER Henry Storch Son	ADDRESS 1301 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92832

1-PLACE OF DEATH St. Joseph's Hospital 8 Registered No.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. G. Wahlhaupter

(a) Residence No. 1604 N. Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Wahlhaupter

6-DATE OF BIRTH (month, day and year) May 15, 1883

7-AGE 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Car Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) U.R.R. 18

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS

10-NAME OF FATHER. John Wahlhaupter

11-BIRTHPLACE (of FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) Mrs John Wahlhaupter

(Address) 1604 N Spring St

15- Filed DEC 11 1924

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1924 to Dec 8, 1924

that I last saw h. alive on Dec 8, 1924

and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Complex

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) DOW

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. B. Sylvest M. D

, 19 (Address) St. Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. 12/12 1924

20-UNDERTAKER. George J. Ruth — ADDRESS 1735 Harford Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D 92833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D 92833

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 22 WARD)

2-FULL NAME James Hanson

(a) RESIDENCE No. 217 W Hill St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1914

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
10 6yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Stevenson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Hanson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Sarah Hanson
(Address) 217 W Hill St

15 Filed DEC 11 1924 NORA R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1924, to Dec 10, 1924,

that I last saw him alive on Dec 10, 1924,

and that death occurred, on the date stated above, at 5.50 p m.

The CAUSE OF DEATH* was as follows:

Tonsil, Pharynx & Laryngeal Diphtheria

(duration) yrs. mos da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 8 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubation Date of 12/9/24

Was there an autopsy? Yes

What test confirmed diagnosis? Positive Nose Culture

(Signed) Myron G. Tull, M. D.

12/11 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cl	Dec 11 1924
20 UNDERTAKER	ADDRESS
L. H. Brown & Son	108 N Mary

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45D 92834

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 N. Collington Ave WARD 8)

2-FULL NAME Wm. F. Casey

(a) RESIDENCE. No. 1846 N. Collington Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Casey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 69 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Ne

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bates, Md

PARENTS

10 NAME OF FATHER Wm. Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bates, Md

12 MAIDEN NAME OF MOTHER Selina Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bates Md

14 Informant Allen Casey Son

(Address) 1846 N. Collington Ave

15 Filed 19 ROBERT R. KRAMER Registrar

DEC 11 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1924, to Dec. 10, 1924

that I last saw him alive on Dec. 10 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage.

(over)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) not Known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test (confirmed diagnosis)?

(Signed) J. E. Pennebacker M. D.

(Address) 1531 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/13 1924

20 UNDERTAKER Edwin Cook & Son E — ADDRESS Cook Co

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92835

CERTIFICATE OF DEATH.

1888 D 92835

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen. Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Williams

(a) RESIDENCE NO. Laurel Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Rachel Williams

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Randolph Williams
(Address) Laurel Md.

15 Filed DEC 11 1924, 192 ROBT. R. KRAUTH, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of 4th & 5th Cervical Vertebrae (accidental) (duration) yrs. mos. 2 ds.
Thrown from wagon by runaway horse (duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)
Dec. 11, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bacons Chapel Laurel Md. DATE OF BURIAL 12/14/24 192

20 UNDERTAKER Ellwood N. Fisher ADDRESS Laurel Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2812 Woodbrook Av St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Frankenberger

(a) Residence No. 2812 Woodbrook Av St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? 74 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: John C. Frankenberger

6-DATE OF BIRTH (month, day and year): July 5, 1848

7-AGE: 76 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Harten

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-
(Informant): John C. Frankenberger
(Address): 2812 Woodbrook Av

15-
Filed ..... 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924 to Dec. 10 1924
that I last saw h.. alive on Dec 10 1924
and that death occurred, on the date stated above, at 9.35 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): General Debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray, Gastric Anal.

(Signed) Paul Jacoulin Nicol M. D.
, 19 (Address) 1013 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem — DATE OF BURIAL, Dec 13 24 19....

20-UNDERTAKER: Harry W. Eblen — ADDRESS 1214 N. Howard St.

Printed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

92837

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 92837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3706 Old Fork Road St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Price Etzaugh

(a) Residence No. 3706 Old Fork Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, Married or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V.

6-DATE OF BIRTH (month, day and year) Oct. 18 1858

7-AGE. 66 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn. R. R.

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Zachariah Etzaugh

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Lavisa Mallows

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-Informant Laura V. Etzaugh

(Address) 3706 Old Fork Road

15-Filed DEC 13 1924 192 Robert P. Harrison Registrar.

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. Dec 10 1924 to Dec 10 1924 that I last saw him alive on Dec 1 1924 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John Etzaugh M. D

Dec 11, 1924 (Address) 700 N. Wolfe

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL, Dec. 12 1924

20-UNDERTAKER, Wm Cook ADDRESS 552 Edmondson

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 St. Peter St., 21 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ruth Carman

(a) Residence No. 802 St. Peter St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Feme

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mdw

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Watson

6-DATE OF BIRTH (month, day and year) 1834

7-AGE. 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Pa (State or Country).

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) Don't Know (State or Country).

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) Don't Know (State or Country).

14- (Informant) T. Carman

(Address) 802 St. Peter

15- Filed DEC 1 1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/1/24

17- I HEREBY CERTIFY, That I attended deceased from 12/1 19 24 to 12/1 19 24 that I last saw him alive on 12/1/24 19 and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

C

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dorsey M. D

, 19 (Address) 1129 Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. 12-2 19 24

20-UNDERTAKER. Wm. Cook ADDRESS 502 E North

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92839

CERTIFICATE OF DEATH.

1827 D 92839

1-PLACE OF DEATH Spedden Shaft Jail, 1

CITY OF BALTIMORE. (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph Gustav Leidenberg

(a) RESIDENCE No. Work House ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work mariner
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Zellmer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Fredrick Schneider
(Address) 7 E. Redwood St.

DEC 13 1924 Filed ..... 192 Robert L. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

12/13/24, 192 (Address) ..... City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Pauls Cemetery	Dec 12 1924
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 92840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92840

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 Fulton Ave. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... David Garratt

(Residence in Baltimore: No. 704 Fulton Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: June (Month) 7 (Day) 1863 (Year)

7-AGE: 61 yrs. 6 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coppage
(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturer

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS:

10-NAME OF FATHER: George Garratt

11-BIRTHPLACE OF FATHER, (State or Country): England

12-MAIDEN NAME OF MOTHER: Margaret Thomas

13-BIRTHPLACE OF MOTHER, (State or Country): Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa M. Garratt

(Address) Mt. Washington

15- Filed DEC 1 1924 19?

Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: DEC 10 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Elliott Wade M. D. (Coroner)

Dec 10/24 (Address) 125 W. Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: Dec 13 1924

20-UNDERTAKER: H. Gander & Sons

ADDRESS: 1710 Fleet St

DEC 1 1924

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks. (Marie Henry) (2601 E. Preston St.)

D 9284 F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9284 F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary 4 100 09

Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Henry

(a) Residence No. 2601 E. Preston Street St., City Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 27 1895

7-AGE. 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Harry Henry

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Martinsburg, Va

12-MAIDEN NAME OF MOTHER, Catherine D. Mueller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

11- (Informant) Catherine Henry

(Address) 2601 E. Preston st.

15- Filed ..... 19..... Robert P. Harrison, Registrar.

Dec 1 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 ..... 1924 ..... to Dec 9 ..... 1924, that I last saw h.e alive on Dec 9 ..... 1924, and that death occurred, on the date stated above, at 4.45 p.m. The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Keith C. Rice M. D

, 19 (Address) Church Home & Inf

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem	12 12 ..., 19 24
20-UNDERTAKER.	ADDRESS
George J. Ruth	1735 Harford Av

If not delivered EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 92842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4th D 92842

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 322 Montwommon St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie MacDonald

(Residence in Baltimore: No. 3422 Mondawmin Ave St.; 6 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, June 6, 1874 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, James R Macdonald

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Elizabeth Duent

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James R Macdonald

(Address) 3422 Mondawmin Ave

15-

Filed ..... 191.....

Robert P. Harrison,

Registrar.

C T 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1924, to Dec 10 1924, that I saw h[illegible] alive on Dec 10 1924, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

..... (Duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. da.

(Signed) [illegible] M. D.

12/12/24, 191... (Address) Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Dec 12, 1924

20-UNDERTAKER Eckenrowth Son ADDRESS 3617 Chestnut Ave.

CAUSE OF DEATH in plain terms, so that it may be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 92343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 92843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. 13 ST., WARD)

2-FULL NAME Theodore Franklin

(a) RESIDENCE No. 414 Millrace Rd Hamden, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
		1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Gibbons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 11 1924, 19 Robert P. Harrison Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11- 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 9- , 1924, to Dec 11- , 1924.

that I last saw ~~him~~ alive on Dec 11- , 1924,

and that death occurred, on the date stated above, at 2 15 a m.

The CAUSE OF DEATH* was as follows:

Erysipelas - Septicemia

(Hemolytic streptococcus)

(duration) — yrs. 7 days

CONTRIBUTORY (Secondary) Pemphigus Neonatorum

(duration) yrs. 7 wks ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture Organism

(Signed) Edmund H Kemper M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hamden	Dec 13 1924
20 UNDERTAKER	ADDRESS
Ehenworth & Son	Chestnut ave

WHITE PAPER. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 92844

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Fitzpatrick

(a) RESIDENCE No. 1310 Ashland ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John C. Bollanger

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Eliza Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 DEC 12 1924 Filed H. R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1920, to Dec. 11, 1924, that I last saw h[illegible] alive on Dec. 11, 1924, and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Richard Pearson M. D.

12-11-24 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 13 1924
20 UNDERTAKER Robt J Turney & Son	ADDRESS 542 N. Broadway

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

92845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 92845

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Strieker ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Smith

(a) RESIDENCE NO. 210 S Strieker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER James F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER Essie Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mother

(Address) 210 S Strieker

15 DEC 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1924, to Dec 10, 1924, that I last saw her alive on Dec 9, 1924, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edgar E. Draper M. D.

, 19 (Address) 1500 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: DEC 12 1924

20 UNDERTAKER: Harry H. Woltzke — ADDRESS: 1531 W Lombard

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1874 92846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-001

D 92846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 16 WARD)

2-FULL NAME James Smith

(a) RESIDENCE NO. 1012 N. Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 25 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bettie Lawson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 12 1924 19 WM. S. KNABLER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1924, to Dec 10, 1924, that I last saw him alive on Dec 10, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12/6/24

Was there an autopsy? Yes

What test confirmed diagnosis? Culture of organism

(Signed) Edmund H. Kenyon, M. D.

12/11, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Arbutus Cem DATE OF BURIAL Dec 13 1924

20 UNDERTAKER James L. Hawley ADDRESS 11 Caddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92847 HEALTH DEPARTMENT—CITY OF BALTIMORE 92847.

CERTIFICATE OF DEATH.

100-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1373 Stricker St ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Lee

(a) RESIDENCE NO. 1373 Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Lewis Lee

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Young

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country) Va

14 Informant Emma Lee (Address) 1373 N. Stricker St

15 Filed DEC 12 1924 Robert S. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11-1924

17

I HEREBY CERTIFY, That I attended deceased from 12-9-, 1924, to 12-11, 1924, that I last saw him alive on 12-10, 1924, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank A. Saunders, M. D.

, 19 (Address) 1133 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Dec 12 1924
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N. Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92848

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09 ✓ 92848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1120 N. Calhoun St. 16 WARD)

2-FULL NAME Ollie Lawrence

(a) RESIDENCE NO. 1120 N. Calhoun St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE colored | 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Larry Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Hattie Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hattie Lawrence
(Address) 1120 N. Calhoun St.

15 Filed DEC 12 1924 Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) nothing

(duration) yrs. mos. ds.

(Signed) Dr. T. Hennessy M. D.
(Coroner.)

Dec. 19, 1924 (Address) 2 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec 12 1924
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92849

CERTIFICATE OF DEATH.

111-001 D 92849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital, 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Grafft

(a) RESIDENCE NO. 1912 Baltelay (Barclay St.) WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Kate Grafft

6 DATE OF BIRTH (month, day, and year) July 27, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Telegraph Operator

(c) Name of employer Pennsylvania R.R.

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER George Grafft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Josphine Hammel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Record & Mrs. Kate Grafft

(Address) 1912 Barclay

15 Filed ....., 19 ..... ROBERT R. KRAUTER Registrar

DEC 12 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/24

17

I HEREBY CERTIFY, That I attended deceased from 12/4/24, 19..... to 12/10/24, 19 .....

that I last saw h me alive on 12/10/24, 19

and that death occurred, on the date stated above, at 11:58 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Post. Gastroenterostomy

Did an operation precede death? Yes. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Dolley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Dec 13 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Kirdy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92850

74-D 92850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Kirdy

(a) Residence No. Preston & Valley St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single, Married, Widowed, or Divorced.~~ Widow (Write the word.)

5a-~~If married, widowed, or divorced~~ HUSBAND ~~of (or)~~ WIFE of Robert Kirdy

6-DATE OF BIRTH (month, day and year) 1848

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Philadelphia Pa.

PARENTS.

10-NAME OF FATHER. Keating

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Duffy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-

(Informant). Sister Florence

(Address). Preston & Valley

15-

Filed....., 192.. [illegible] R. KRAUTER Registrar.

DEC 1 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 11/24

17- I HEREBY CERTIFY, That I attended deceased from No Record, 19..., to ..., 19...,

that I last saw h.. alive on Dec 10, 1924,

and that death occurred, on the date stated above, at 12. A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

2 days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Dec (Signed) F A Warner, M. D.

11, 19 24 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL, 12/13, 19 24

20-UNDERTAKER. Chas. P. Maud Son

ADDRESS 11 E. North Ave.

Instructions on back of certificates.

in plain terms, so that it may be properly classified.

...red EXACTLY. PHYSICIANS should state CAUSE OF DEATH ...fied. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92851

CERTIFICATE OF DEATH.

31 D 92851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Druid Hill Ave ST. 11 WARD)

2-FULL NAME Annie B. Thuson

(a) RESIDENCE NO. 1215 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Oscar Thuson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 41 — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lang & Brown Co

PARENTS

10 NAME OF FATHER: Agnus Swathney

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Alice Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Wm Oscar Thuson

(Address) 1215 Druid Hill Ave

15 Filed DEC 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 27, 1924, to Dec 10, 1924,

that I last saw h alive on Dec 9, 1924;

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

1a. Pulmonary Tuberculosis.

Coma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Asthenia.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological.

(Signed) W. J. Carr, M. D.

Dec. 12, 1924 (Address) 5-15 Hooker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: DEC 12 1924

20 UNDERTAKER: Samuel Hemsley

ADDRESS 578 N Bidd St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92852

CERTIFICATE OF DEATH.

74-001

74 D 92852

REGISTERED NO.....

1-PLACE OF DEATH 1420 Mill Race Road.

CITY OF BALTIMORE: (No. 1420 Mill Race Rd. St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Everhart.

(a) RESIDENCE. No. 1420 Mill Race Rd St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. 8 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine E. Everhart

6 DATE OF BIRTH (month, day, and year) April 10 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.	8.	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Geo. S. Everhart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Lauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Katherine E. Everhart. (Address) 1420 Mill Race Road.

15 Filed DEC 12 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 11, 1924, that I last saw him alive on Dec 10, 1924, and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J Davies, M. D.

12-11-1924 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: 12/13. 1924

20 UNDERTAKER: Walter Davis ADDRESS: 3307 Paint St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 92853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 9 WARD)

2-FULL NAME William Williams

(a) RESIDENCE No. 2833 Reese st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cement worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: William Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Emma Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital records (Address) U.T.H.

15 Filed DEC 21 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1924, to Dec. 10, 1924, that I last saw him alive on Dec. 10, 1924, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, lab.

(Signed) R. A. Short, M. D.

12-10-24 (Address) Municipal tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Rest Cem Towsontown — DATE OF BURIAL: Dec 11 1924

20 UNDERTAKER: Mrs R A Elliott — ADDRESS: 1735 Ashland Ave.

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92854

CERTIFICATE OF DEATH.

90 D 92854

1-PLACE OF DEATH Hebrew Hosp. — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 6 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Brill

(a) RESIDENCE No. 6 W Bond st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	age 50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Brill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mildred Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Brill
(Address) Washington D. C.

15 Filed DEC 12 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 11 1924

17 I HEREBY CERTIFY, That I attended deceased from 12 - 2, 1924, to 12 - 11, 1924, that I last saw him alive on 12 - 11, 1924, and that death occurred, on the date stated above, at 11:05 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Ch. Bronchitis and Emphysema (duration) 23 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidore D. Levy, M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Neming Run	12/12 1924
20 UNDERTAKER	ADDRESS 1127
Sol Levinson & Bro	E Balto st

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92855

CERTIFICATE OF DEATH.

101 D 92855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. Lanvale ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Mudge

(a) RESIDENCE NO. 211 W. Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margret L. Mudge

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1858

7 AGE: 66 (Years / Months / Days) — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Accountant

(b) General nature of industry, business, or establishment in which employed (or employer): Paper

(c) Name of employer: Dofler + Mudge

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Abner B. Mudge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lynn, Mass

12 MAIDEN NAME OF MOTHER: Catherine Phillyes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: C. T. Mudge, 3rd

(Address) 211 W. Lanvale St. Balto. Md

15 Filed DEC 12 1924 ROBERT R. KRAUTER, Registrar

~~Burial Permit Issued~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1924, to Dec 11th, 1924, that I last saw h[illegible] alive on Dec 11th, 1924, and that death occurred, on the date stated above, at 4.45P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Lefstuvt, M. D.

12/14, 1924 (Address) 211 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Cremation

DATE OF BURIAL: 12-13 1924

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Orchard Mecculloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1924 92856

CERTIFICATE OF DEATH.

D 92856

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Nicholson

(a) RESIDENCE NO. Ferndale, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 21 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Gertrude Squarey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Record JOHNS HOPKINS HOSPITAL

15 Filed DEC 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1924, to Dec 10, 1924, that I last saw h alive on Dec 10, 1924, and that death occurred, on the date stated above, at 10:20 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

about

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ferndale Md

Did an operation precede death? Yes Date of Dec 10 1924

Was there an autopsy? ~~Had~~ No

What test confirmed diagnosis? I

(Signed) Warfield M Jones, M. D.

19 (Address) J H Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamb Ridge — DATE OF BURIAL Dec 12 1924

20 UNDERTAKER George L. Schnauffer — ADDRESS undertaker

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 92857

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1311 Greenmount Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. Sleger

(a) Residence No. 1311 Greenmount Ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced. HUSBAND of ~~(or) WIFE of~~ Maggie E Sleger

6-DATE OF BIRTH (month, day and year) Mar 15 1866

7-AGE. 58 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). Pa Ry Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. William G Sleger

11-BIRTHPLACE OF FATHER (city or town) (State or Country). York Pa

12-MAIDEN NAME OF MOTHER. Caroline Kissmeyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). York Pa

14- (Informant) Maggie E Sleger

(Address) 1311 Greenmount Ave

15- DEC 12 1924 By: ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 11/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 19th 1924 to Dec 11 1924

that I last saw him alive on Dec 11 1924

and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Sepsis, from infection through Tonsils

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) acute Endocarditis

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 10/24

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) Sherman R. Wantz M. D.

12-11, 1924 (Address) 866 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Millersburg Pa

DATE OF BURIAL. Dec 13, 1924

20-UNDERTAKER. A S Marshall

ADDRESS 3539 Old Road

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92858

CERTIFICATE OF DEATH.

159-002

159 D 92858

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 W. Lafayette St. 11th WARD)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. 1306 W. Lafayette St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) (Infant)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Amos Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosa Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Amos Johnson
(Address) 1306 W. Lafayette St.

15 Filed 12 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale.

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 11, 1924 (Address) 2502 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL H. Grace

DATE OF BURIAL Dec 12 1924

20 UNDERTAKER Wm. H. Chase & Son

ADDRESS 1402 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92859 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3224 E. Baltimore St., 1b Ward) Registered No. 91

2-FULL NAME Harry A. Hughes

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3224 E. Baltimore St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): M.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie E. Hughes

6-DATE OF BIRTH (month, day and year): Oct 13, 1859

7-AGE: 65 yrs. 1 mos. 27 ds. If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Foreman Shipyard

(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco Works

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Joseph Hughes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Mary J. Evans

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14 (Informant): Bessie E. Hughes

(Address): 3224 E. Baltimore

15- Filed DEC 14 1924 192 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1924 to Dec 11 1924

that I last saw h.. alive on Dec 10 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurysm

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rupture through Chest Wall

(Duration) Sudden yrs. mos. ds.

18-Where was disease contracted if not at place of death? (over)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb W. Athey M. D

Dec 13 1924 (Address) 100 S Potteran Parkway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Dec 13, 1924
20-UNDERTAKER, Zirkler & Zirkler	ADDRESS 1739 Eager St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-25-21—E.B.R.S.—400 Bks.

D 92860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92860

CERTIFICATE OF DEATH.

9 101

1-PLACE OF DEATH

City of BALTIMORE: (No. 1618 E. 29th St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie H. Schmeiser

(a) Residence No. 1618 East 29th St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) George Schmeiser

6-DATE OF BIRTH (month, day and year) May 9, 1894

7-AGE: 30 yrs. 7 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

637

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: Wm Zimmerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Louisa Kattus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Geo. Schmeiser

(Address): 1618 E. 29th st

15- Filed ..... 1924 (Signature) ..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1924, to Dec 11th, 1924, that I last saw her alive on Dec 11th, 1924, and that death occurred, on the date stated above, at 9A. m. The CAUSE OF DEATH* was as follows:

Pulmonary Oedema & decompensatio of Heart Heart

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examin

(Signed) Amelia V. Zimmerman, M. D

, 19 (Address) 1605 W. North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: Dec 15, 1924

20-UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1739 Eager st

DEC 1 1924

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92861

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Winfield

(a) RESIDENCE NO. 531 McMechen ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) St. Marys Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER John Winfield

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 31 1924 Robert P. Harrison, .19.....
Registrar
District Number 2039

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-2-, 1924, to 12-9, 1924 that I last saw him alive on 12-8, 1924 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis;
Auricular Fibrillation;
Myocardial Insufficiency

(duration) ... yrs. 4 mos. (Estimated)

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lot

(Signed) Claude S. Drake, M. D.

12-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19.....

20 UNDERTAKER Com. of Health,
Per. Wm. E. Woodall

ADDRESS

DEC 12 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92862

CERTIFICATE OF DEATH.

D 92862

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Thomas

(a) RESIDENCE No 1139 Mc Elderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Homer Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C

14 Informant Municipal Hospital Keyd (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 12 1924, 19 Robert P. Harrison, Registrar

2040 Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-12, 1924, to 12-9, 1924

that I last saw him alive on 12-9, 1924

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic Myocarditis (Degenerative), Myocardial Insufficiency

(duration) 1 yrs. (Guess) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Drace, M. D.

12-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Dr. Wm. R. Woodall

DEC 12 1924

Commissioner of Health,

DEC 12 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of place of death is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92863

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 92863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earnest Andrews

(a) RESIDENCE NO. 902 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'K'D

(c) Name of employer

9 BIRTHPLACE (city or town) ? (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ....., 19.... Registrar

Robert P. Harrison, Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-8, 1924, to 12-8, 1924

that I last saw him alive on 12-8, 1924

and that death occurred, on the date stated above, at 8 05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Drane M. D.

12-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 12 1924

20 UNDERTAKER

ADDRESS

Commissioner Health.

Wm. F. WOODALL

DEC 9 1924

2044

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92864

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Essex ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LUDWIKA JANECZKA,

(a) RESIDENCE No. 2226 Essex ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 34 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Married,

5a If married, widowed, or divorced

or) Wife of Frank Janeczki,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Matthew Kruszynski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Katherine Witkowski

12/1/24

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Frank Janeczki, (Husband)

(Address) 2226 Essex Street

15 Date 12 1924, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1 19 24

17 I HEREBY CERTIFY, That I attended deceased from 12-5 , 19 24 , to 12-18 , 19 24

that I last saw her alive on 12-18 , 19 24

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Felix Jendrisz M. D.

19 (Address) 700 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. [illegible] Cemetery.

DATE OF BURIAL Dec. 13 1924.

20 UNDERTAKER M. F. Sadowski

ADDRESS 705 S. Ann St

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92865 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 16 Harrison St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Jas~~ Dimitrios Kolothros

(a) Residence No. 16 Harrison St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married ~~Widowed~~, or ~~Divorced~~, (~~Write the~~ word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) May 15 1864

7-AGE. 60 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dish washer

(b) General nature of Industry, business, or establishment in which employed (or employer) Restaurant ?

(c) Name of employer ?

9-BIRTHPLACE (city or town) Andros
(State or Country), Greece

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) Andros
(State or Country), Greece

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Andros
(State or Country), Greece

11-
(Informant) John Drenas
(Address) 16 Harrison St

15-
Dec 21 1924 192 Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/10/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 19 24 to Dec 10 19 24

that I last saw him alive on Dec 10 19 24

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. days

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. days

18-Where was disease contracted if not at place of death? ✓ (over)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Thos E Faulson M. D

. 19 (Address) 6 S. Exeter St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery

DATE OF BURIAL. 12/13 19 24

20-UNDERTAKER. Jack Lewis

ADDRESS 1434 Bank St

In order to secure EXACTLY: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92866 ✓

D 92866

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1432 Henry Street St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Theresa Freburger

(a) Residence No. 1432 Henry Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Freburger

6-DATE OF BIRTH (month, day and year) Apr. 22nd, 1842

7-AGE, 82 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore County (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Thierion

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), France

12-MAIDEN NAME OF MOTHER Elizabeth Brooks

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- Miss Edith Freburger (Informant)

(Address) 1432 Henry Street

15- Filed DEC 12 1924, 19.. Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1924, to Dec 10, 1924, that I last saw h.. alive on Dec 10, 1924, and that death occurred, on the date stated above, at 11.40 mP

The CAUSE OF DEATH* was as follows:

Aortic Incompetency

Yrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. McSeabury, M. D.

12-11-24 (Address) 638 E. Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL, Dec 15 1924

20-UNDERTAKER, Joseph B Cook ADDRESS 1003 W Balto St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state CAUSE OF DEATH

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92867

CERTIFICATE OF DEATH.

90 D 92867

1-PLACE OF DEATH St. Joseph's Hosp 4/2 Registered No.....

City of BALTIMORE: (No..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Moran

(a) Residence No. ~~813~~ 1708 Fremont Ave St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 17 1846

7-AGE. 78 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Lily

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS:

10-NAME OF FATHER Michael Moran

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Julia Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) James R Horgan

(Address) 1 Kilbourne Place

15- Filed Dec 21 1924 [Robt. E. Harrison] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 10. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 8, 1924 to Dec 10, 1924 that I last saw h.. alive on Dec 10, 1924 and that death occurred, on the date stated above, at 9 05 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with Decompensation

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Sybert M. D

19 (Address) St. Jos. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL, Dec 13 1924

20-UNDERTAKER Wm Cook — ADDRESS 502E Fort Ave

Burial Permit (Clerk)

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92868

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd & Calvert ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathryn Shawn

(a) RESIDENCE NO. 2709 W. North ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1906.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Shawn

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Whittum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mother - Same address
(Address)

15 Filed , 19 Registrar

DEC 1 21924

Robert L. Morrison, Local Health Officer.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1924, to Dec. 12, 1924, that I last saw her alive on Dec. 12, 1924, and that death occurred, on the date stated above, at 1 40 a. m.

The CAUSE OF DEATH* was as follows:

(1) Acute pneumonia (2) Brain abscess

(duration) yrs. (1) 1 mos. (2) 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 11, 1924.

Was there an autopsy? No

What test confirmed diagnosis? Drainage of abscess

(Signed) CB Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. *(See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec, 13 1924

20 UNDERTAKER: Lowe Cook — ADDRESS: 802 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks. Agne May Dixon

D 92869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 422 Grindall St., 24 Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes May Dixon

(a) Residence No. 422 Grindall St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Dixon

6-DATE OF BIRTH (month, day and year) Aug 9th 1873

7-AGE: 51 yrs. 4 mos. 3 ds. — If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): York

PARENTS.

10-NAME OF FATHER: George Austin

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Rebecca Chaney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa

14- (Informant) William L. Dixon
(Address) 422 Grindall St.

15- Filed ..... 192 ..... Registrar.

DEC 17 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1924 to Dec 12 1924, that I last saw h[illegible] alive on Dec 11 1924, and that death occurred, on the date stated above, at 7:2[illegible] m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) H. L. Birnbaum M. D

(Address) 109 W. Lexington St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL, Dec 15, 1924

20-UNDERTAKER: Wm Cook — ADDRESS 502 E North

Robert F. Harrison
Principal Vital Clerk.

CAUSE OF DEATH is very important. ... Exact statement of OCCUPATION is very important. ... Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92870

CERTIFICATE OF DEATH.

D 92870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 William ST. 34 WARD)

2-FULL NAME Thos G. Forrester

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1506 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12.11.1856

7 AGE 68 Years | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gilder

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Patrick Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER O'Hollander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas L. Forrester

(Address) 506 William St.

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk.

DEC 12 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.11. 1924

17 I HEREBY CERTIFY, That I attended deceased from 12.10. 1924 to 12.11 1924

that I last saw him alive on 12.11 1924

and that death occurred, on the date stated above, at 7. a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia 1 yr 8 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency 1 yr 8 mos

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. J. Sterlinghus, M. D.

12/11 1924 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Dec 15 1924

20 UNDERTAKER F. A. Krause & Sons

ADDRESS 1087 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92871 — CERTIFICATE OF DEATH. — 92871

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: No. ... St., ... Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Byrd

(a) RESIDENCE NO. 1205 Argyle Ave St., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. Byrd

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ... min.
	52	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Writer 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) S. Carolina

10 NAME OF FATHER Aaron Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha Byrd (Address) 59 Young & Winchester Sts

15 Filed ... 192 Robert P. Harrison, Registrar

CT 21924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardio Renal Sclerosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)
... 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence Phila. Pa.

19 PLACE OF BURIAL CREMATION OR REMOVAL Charlotte N. C. — DATE OF BURIAL 12-12-1924

20 UNDERTAKER Samuel T. Hemsley — ADDRESS 570 N. Eddy St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92872

CERTIFICATE OF DEATH.

D 92872

90

1-PLACE OF DEATH St. Joseph's Hosp. 9 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Anna Gardner

(a) Residence No. 1304 Hillman ave St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Dennis Gardner

6-DATE OF BIRTH (month, day and year) Unknown 1854

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER Martin Cunningham

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Rev John F Gardner

(Address) St Chas College

15- Filed. 192 Registrar.

C 1 27524 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 10 - 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 14, 1924 to Dec 10, 1924

that I last saw h. alive on Dec 10, 1924

and that death occurred, on the date stated above, at 4 20 P.M.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Complet

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Sweeney, M. D.

, 19 (Address) St Jos Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral	Dec 13, 1924
20-UNDERTAKER,	ADDRESS
H. C. Miedfeld	914 Greenmt Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10 21—M&T 1500 Bks.

D 92873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Riverside Dr. ST., 24 WARD)

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kermit F. Phelps.

(a) RESIDENCE NO. 1029 Riverside ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb. 13-1924

7 AGE: Years — Months: 9 — Days: 10 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Elmer D. Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Annie Shea.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Elmer D. Phelps.

(Address) 1029 Riverside Ave.

15 Filed DEC 12 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1924, to Dec 11, 1924,

that I last saw him alive on Dec 11, 1924,

and that death occurred, on the date stated above, at 12 0 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary): Whooping Cough

(duration) yrs. mos. 2 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys + History

(Signed) Mulctaylor, M. D.

12/12 1924 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Dec 13 1924

20 UNDERTAKER: George A. Schnabel — ADDRESS: Erdman Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 12 1924

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92874

CERTIFICATE OF DEATH.

X 60 D 92874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Neal

(a) RESIDENCE NO. Anundel Co. Md. ST., WARD West River Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Neal.

6 DATE OF BIRTH (Month, day, and year) [illegible] 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mercy Hospital Record.

(Address)

15 Filed DEC 12 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11/24

17

I HEREBY CERTIFY, That I attended deceased from 12/8/24, 19..... to 12/11/24, 19.....

that I last saw he alive on 12/11/24, 19.....

and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

Toxic Columna Thyroid

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Septicemia. Cardiac Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical Picture

(Signed) K. W. Dolley, M. D.

, 19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West River md	Dec 13 1924
20 UNDERTAKER Mr Jas H. Dennis per T. E. Nelson.	ADDRESS 1303 Pulaski St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92875

D 92875

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Clendenin ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marshall. E. Booze

(Residence in Baltimore: No. 1202 Clendenin St.; 61 yrs. ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Married

6-DATE OF BIRTH, December (Month) 10th (Day), 1863 (Year)

7-AGE, 61 yrs. ✓ mos. ✓ ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Booze

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lila Griffin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannie Booze

(Address) 1202 Clendenin St

15- DEC 12 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30th 1924, to Dec 10th 1924, that I saw him alive on Dec 10th 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ✓ yrs. ✓ mos. 10 ds.

CONTRIBUTORY (Secondary) Penitonitis

(Duration) ✓ yrs. ✓ mos. 3 ds.

(Signed) A. A. Glascock M. D.

12/10/24 1924 (Address) 1202 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemtery

DATE OF BURIAL, Dec. 13., 1924

20-UNDERTAKER Mrs Gus H. Dennis

ADDRESS 1393 Pressman St

Per, E Kelson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92876

CERTIFICATE OF DEATH.

5 164

D 92876

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 422 N. Caroline St. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Richardson

(a) Residence No. 422 N. Caroline St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Richardson

6-DATE OF BIRTH (month, day and year) June 13 1840

7-AGE.	If LESS than 1 day.
84 yrs. 5 mos. 28 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER. Jacob Hauser

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country).

12-MAIDEN NAME OF MOTHER. Elizabeth Knight

13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country).

11- (Informant) Miss Richardson
(Address) 422 N. Caroline St.

15- [illegible] 192.... Registrar.
Robert F. Harrison,
Burial Permit Clerk

DEC 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-11-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Dec 11 1924

that I last saw h[illegible] alive on Dec 10 19 24

and that death occurred, on the date stated above, at 6 Am. m.

The CAUSE OF DEATH* was as follows:

Infirmities of aged age

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Dec 12 1924 (Signed) R. H. Campbell M. D
(Address) 1644 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cemetery	12-13-24 19....
20-UNDERTAKER.	ADDRESS
I. Fos McCully	130 S. Fort

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—160 Blks.

D 92877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D 92877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 Light St. ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Matthews.

(a) RESIDENCE NO. 1742 Light St. ST., WARD

(Usual place of abode) On visit of 3 mos. from Cumberland.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or ~~divorced~~ (or) WIFE of Charles J.Matthews.

6 DATE OF BIRTH (month, day, and year) April 11,1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Jefferson W.Va.
(State or country)

PARENTS

10 NAME OF FATHER Robert Thompson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia.

12 MAIDEN NAME OF MOTHER Martha Steele

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Virginia.

14 Informant Martha J.Sarton.(daughter)
(Address) 1742 Light St.

15 Filed DEC 12 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11,1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto H. Reinhardt (Coroner.) M. D.

Dec 12, 1924 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Hill Cem Martinsburg W.Va.

DATE OF BURIAL 12/13 192 4

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E. Front

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101 001 D 92878

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Weston

(a) Residence No. St. Charles College Catonsville Md. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec Eleven 1874

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St. Charles College

9-BIRTHPLACE (city or town) (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14- (Informant) William Weston

(Address)

15- Filed 192 Robert P. Harrison, Registrar.

C 1 3 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-12-24

17- I HEREBY CERTIFY, That I attended deceased from 12-9 1924 to 12-12 1924 that I last saw him alive on 12-12 1924 and that death occurred, on the date stated above, at 7:2 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. T. Owens M. D

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mondawmin Dec. 17 1924

DATE OF BURIAL.

20-UNDERTAKER, Jos. J. Neu

ADDRESS 156 N. Luzerne

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 92879 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92879

CERTIFICATE OF DEATH. 4 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 47 W Franklin Avenue St., 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Shawker

(Residence in Baltimore: No. 47 W. Franklin Avenue St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. 1840
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
84 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Trucker
(b) General nature of Industry, business, or establishment in which employed (or employer): (self)

9-BIRTHPLACE, (State or Country). Howard County, Maryland

PARENTS.

10-NAME OF FATHER. Daniel Shawker

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Knapp

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Joseph Shawker
(Informant)
1431 Washington Blvd.
(Address)

15- Filed 1924 Robert P. Harrison, Registrar.
C 131924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10th or 11th, 192 4
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility & exposure
(Duration) yrs. mos. ds.

(Signed) J. Ford Tailor M. D.
(Coroner.)
12-12 192 4 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cem	Dec 13" 24
20-UNDERTAKER,	ADDRESS
Geo. L. B. Cook	100 3/4 N. Dallas St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92880

D 92880

CERTIFICATE OF DEATH.

Registered No. 117

1-PLACE OF DEATH

City of BALTIMORE: (No. 1110 East 20th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Susan G. Miller

(a) Residence No. 1110 East 20th St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John E Miller

6-DATE OF BIRTH (month, day and year) Nov 11 1864

7-AGE. 60 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Fredericksburg Va

PARENTS.

10-NAME OF FATHER. Ruben Zellers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Fredericksburg Va

12-MAIDEN NAME OF MOTHER. Lusetta Fauver

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Fredericksburg Va

14-

(Informant) Husband John E Miller

(Address) 1110 East 20th St

15-

Filed Dec 31 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 12/924

17- I HEREBY CERTIFY, That I attended deceased from Dec 9, 1924 to Dec 12, 1924

that I last saw her alive on Dec 11, 1924

and that death occurred, on the date stated above, at 5.25 a. m.

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy for acute

Dep. Hypertrophy (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 3

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry [illegible] M. D.

Dec 12 1924 (Address) 1100 E 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Lebanon Pa via Phila RR.	Dec 14. 1924
20-UNDERTAKER. John F Denny	ADDRESS 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 92881 HEALTH DEPARTMENT—CITY OF BALTIMORE D 92881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital No. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. Hubig

(a) RESIDENCE NO. Essex ST. Balto Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellenora Hubig

6 DATE OF BIRTH (month, day, and year) Sept 5 1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Proof Reader.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hals Bargis House

9 BIRTHPLACE (city or town) (State or country) Brooklyn N.Y.

PARENTS

10 NAME OF FATHER John Hubig

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Poulsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark.

14 Informant Ellenora Hubig.
(Address)

15 Filed DEC 13 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental. Fall, Fracture of Skull. (Coro.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner.)
192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Parkcemetery	Dec 13, 1924.
20 UNDERTAKER John A. Moran	ADDRESS 3000 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92882

CERTIFICATE OF DEATH.

X 46D 92882

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 W. Preston ST., 11 WARD)

2-FULL NAME Rosa Dubose

(a) RESIDENCE NO. 239 W. Preston ST., Sumpter WARD S. Carolina
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Melvin Dubose

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	36	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 110

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sumpter S.C.

PARENTS

10 NAME OF FATHER Nathaniel Evans

11 BIRTHPLACE OF FATHER (city or town) Sumpter (State or country) S.C.

12 MAIDEN NAME OF MOTHER Ros Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Alvay Delrass (Address) 239 W. Preston St

15 Filed ..... 19 ..... Registrar

C 13 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2d, 1924, to Dec. 10th, 1924, that I last saw her alive on Dec 10th, 1924, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows: Cancer of the uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Profuse flow thereof (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Sumpter, S. C.

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical

What test confirmed diagnosis?

(Signed) H. Lee Edwards, M. D.

12/12, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumter S. C. DATE OF BURIAL 12-13-24

20 UNDERTAKER Daniel Easter ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92883

CERTIFICATE OF DEATH.

D 92883

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 Sheldon Place St., 17 Ward)

Registered No. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Roberts

(a) Residence No. 911 Sheldon Place St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-12-24

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, 1 hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Roberts

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Bessie Daly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Edna Roberts

(Address) 911 Sheldon Pl

15- Filed 12 192 Robert F. Hall, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-12-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924, to Dec 12, 1924, that I last saw h alive on Dec 12, 1924, and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Stewart, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt Auburn	12-13-24
20-UNDERTAKER	ADDRESS
Dann Eastern	916 E Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92884

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1418 Ward St St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Slater

(a) Residence No. 1418 Ward St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-Single, Married, Widowed or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Don't Know

7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Del

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know

14- (Informant): Mary E. Slater

(Address): 1418 Ward St

15- Filed 192 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12-10-24

17- I HEREBY CERTIFY, That I attended deceased from 12-5- 1924 to 12-10- 1924

that I last saw h[illegible] alive on 12-10 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Brown M. D.

, 19 (Address) 1 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 12-13- 1924
Mt Auburn Cem	
20-UNDERTAKER. David Easton	ADDRESS 912 Eutaw

In order to correctly classified. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92885

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bell

(a) RESIDENCE No. 919 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Jane Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lillian Bell (Address) 919 Druid Hill Ave

15 Filed , 19 Registrar

DEC 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10-24

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1924, to Dec 10, 1924, that I last saw him alive on Dec 10, 1924, and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration with aortic regurgitation

No syphilis

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) Zadus E Taggart, M. D.

, 19 (Address) 814 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cabury Can	12-14-24
20 UNDERTAKER	ADDRESS 916
David Carlson	Ca an

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92886

CERTIFICATE OF DEATH.

74-001
74 D 92886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 McCulloh St. WARD)

2-FULL NAME Louis Shipley

(a) RESIDENCE NO. 2113 McCulloh St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos. Shipley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ida Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Shipley (Address) 2113 McCulloh St.

15 Filed ..... 19 Robert P. Harrison, Registrar

DEC 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th 1924. to Dec 9th 1924.

that I last saw him alive on Dec 9 1924.

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypertension (High Blood Pressure) (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Gust Hall, M. D.

, 19 (Address) 426 E 3 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morning Star Cem	12-13-24
20 UNDERTAKER Denk Eaton	ADDRESS 916 E 6 St

Cor.—1-12-23—M&T—100 Bks.

D 92887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92887

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1547 Bruce St., ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Turner

(a) RESIDENCE NO. 1547 Bruce St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) job
(c) Name of employer Seely

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Nellie Rice
(Address) 172 Christopher

15 Filed DEC 13 1924, 192 Robert F. Harrison, Registrar

Deputy Health Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 11, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-13-24
20 UNDERTAKER David Easton	ADDRESS 916 Cars

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Blks.

D 92888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92888

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Dickman ST., 23 WARD)

2-FULL NAME Martin L Healy

(a) RESIDENCE No. 201 Dickman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Conway

6 DATE OF BIRTH (month, day, and year) Dec 11 1860

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 0440

(b) General nature of industry, business, or establishment in which employed (or employer) W. M. Rail Road

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Healy
(Address) 201 Dickman St.

15 DEC 31 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Dec 11 1924

that I last saw him alive on Dec 11 1924

and that death occurred, on the date stated above, at 1 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test [redacted] Clinically

(Signed) [redacted] Campbell M. D.

Dec 12 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Dec 16 1924
20 UNDERTAKER Chas L. Stevens	ADDRESS 1501 E Fayette St

C 13 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92889

HEALTH DEPARTMENT—CITY OF BALTIMORE

92889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3928 Park Heights ave. ST.: 15 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L. Betts

(a) RESIDENCE. No. 3928 Park Heights ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daisy L Betts

6 DATE OF BIRTH (month, day, and year): Dec 9 59

7 AGE: Years 65 Months — Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Living Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Meth Bro

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Daisy L Betts

(Address): 3928 Park Heights

15 Filed DEC 31 1924 19 Robert T. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1924, to Dec. 11, 1924, that I last saw him alive on Dec. 11, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Mitral Insufficiency

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm R. Johnson, M.D.

12/11, 1924 (Address) 3928 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Dec 13 192[illegible]

20 UNDERTAKER: H M Routson

ADDRESS 223 N [illegible] St.

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

AFFIX STAMP

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92890

CERTIFICATE OF DEATH.

D 92890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3707 Chestnut Rd (St.; Wilbrook 15 WARD)

REGISTERED NO. C 761

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles B. Spencer

(Residence in Baltimore: No. 3707 Chestnut Rd St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, June 16, 1861
(Month) (Day) (Year)

7-AGE, 63 yrs. 6 mos. 24 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Banker
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Vermont.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna K. Berg

(Address) 3707 Chestnut Rd

15- Filed DEC 13 1924, 191 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 10 th, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1924, to Dec 10 1924, that I saw h- alive on Dec. 10. 1924, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Arterial Sclerosis
Gen. paresis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute paresis
(Duration) yrs. mos. ds.

(Signed) Thos. H. Hillsinger M. D.
12-12, 1924. (Address) 2300 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rides here Westminster Md

DATE OF BURIAL, Dec 13., 1924

20-UNDERTAKER W M Routson

ADDRESS 2238 N Howard

DEC 13 1924

Vital Records Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92891

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 N. Fayette St. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph R. Childress

(a) RESIDENCE No 1528 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Childress

6 DATE OF BIRTH (month, day, and year) Oct 7th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) U.R.T.&E. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Joseph T. Childress

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Ellett

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lucy A. Chapman
(Address) 1592 W. Fayette St

15 Filed ..... 192 Robert F. [illegible] Registrar

C 131924 Burial Permit C[illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. 15 Min ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. ds.

(Signed) Thos. R. Horton M. D.
Coroner

Dec 12th 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	12/13/24 192

20 UNDERTAKER Em. Weber & Son 2503 ADDRESS Edmonds

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 92392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Barclay ST.; 12 WARD)

REGISTERED NO. C 1679

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Koble

(Residence in Baltimore: No. 222 Barclay St.; [redacted] yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. 12 (Month) 12 (Day), 1924 (Year)

7-AGE. 14½ hours. yrs. mos. ds. If LESS than 1 day, 1 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER Anna Koble

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary T. Vaughan

(Address) 1028 Valley St

15-

Filed [illegible], 191

Registrar.

OCT 3 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 12 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I saw her alive on Dec 12 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
Just breathed 1 1/2
Thrush & died

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mary T. Vaughan M. D.

12-12, 1924 (Address) 1028 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Dec. 13, 1924
20-UNDERTAKER,	ADDRESS
H. C. Wedefield	9 + Gruman Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 92893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92893

CERTIFICATE OF DEATH.

Joseph Kirzkauskas

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 27 WARD)

REGISTERED No. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Krigbauskas

(a) RESIDENCE No. 418 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Clement Krigbaukas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Kuncevicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Municipal Hospital Record (Address)

15 Dec 13 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-25, 1924, to 12-12, 1924, that I last saw him alive on 12-12, 1924, and that death occurred, on the date stated above, at 8:30a m.

The CAUSE OF DEATH* was as follows:

C.N.S Syphilis (Meningo-Vascular).

(duration) ? yrs. 4 mos. (History) ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Aut.

(Signed) Claude T. Dove M. D.

12-12 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 15. 1924
20 UNDERTAKER	**ADDRESS**
John Grebliauckas J.G.	425 S Paca. St

C 13 1924

mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92894

CERTIFICATE OF DEATH.

D 92894

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Fulmore St., WARD) 9

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kirk Houghton

(a) RESIDENCE NO. 1137 Fulmore St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Franklin P. Houghton

6 DATE OF BIRTH (month, day, and year) May 28 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jordan Pinkerton

11 BIRTHPLACE OF FATHER (city or town) Belfast
(State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant James Dr. Houghton
(Address) 1137 Fulmore St

15 Filed DEC 13 1924, 19 Robert L. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 23rd, 1924, to Dec 10, 1924, that I last saw her alive on Dec 10, 1924, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) J. C. Young, 5117 Pimlico Rd M. D.

12/13/1924 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 12/12 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 92895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 Rabory st ST., 4 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Broghus

(a) RESIDENCE NO 643 Ruborg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) B C, Balto. md

PARENTS

10 NAME OF FATHER Joe Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry James (Address) 642 Rabory st.

15 Filed DEC 13 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos 7 ds.

(Signed) W R Lee Jr, M. D. (Coroner.)

12-13, 1924 (Address) 111 N Gaston st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 14th 1924
20 UNDERTAKER A. Jones	ADDRESS 1111 Edna st

TION is very important. See instructions on back of certificate.

D 92896

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 92896

(PLACE OF DEATH

REGISTERED No. C 17

CITY OF BALTIMORE (No. 1412 Hollins St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie J Weaver

(Residence in Baltimore: No. 1412 Hollins St. St.: 50 yrs. mos ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May 15th, 1869 (Month) (Day) (Year)

7-AGE: 55 yrs. 3 mos. 11 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Co.

PARENTS

10-NAME OF FATHER: Thomas Weaver

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Martha E Weaver

13-BIRTHPLACE OF MOTHER (State or country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William F. Weaver

(Address) 1412 Hollins St

15.

Filed ..... 191 Robert F. Harrison, REGISTRAR

Burial Permit Clerk.

DEC 13 1924

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 12 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1924, to Dec 11th 1924, that I saw her alive on Dec 11th, 1924, and that death occurred on the date stated above, at 12.24 m.

The CAUSE OF DEATH* was as follows:

Melancholia

(Duration) yrs. mos. 17 ds

Contributory (SECONDARY) Hypostatic Congestion

(Duration) yrs. mos. 3 ds.

(Signed) Ira L Lambert M. D.

Dec 12th, 1924 (Address) 132 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: December 15 1924

20-UNDERTAKER: George J Smith — ADDRESS: 1532 Hollins St

Cor.—1-12-23—M&T—100 Bks.

D 92897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92897

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Greenmount Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily S. Henderson

2403 Greenmount Ave

(a) RESIDENCE NO ..... ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Henderson

6 DATE OF BIRTH (month, day, and year) Oct 6/1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Leonard J. Bondel

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Anna M Mettel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C.A. Bondel
(Address) 3816 Bonner Road

15 Filed DEC 13 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency- probably Myocardial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

(Signed) J. S. H. Culler, M. D.
(Coroner.)

12/12/24 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Dec 13 1924

20 UNDERTAKER W. M. Cook — ADDRESS 532 E. North Ave

IMPORTANT—RECORD Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92898

D 92898

CERTIFICATE OF DEATH.

41

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Womens Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mrs. Sallie Lyons

(a) Residence No... 1169 Washington Blvd. St.,..... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widow Widowed, ~~or Divorced~~. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Lyons

6-DATE OF BIRTH (month, day and year) Nov 19, 1869

7-AGE, 55 yrs. — mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Dont Know

14- (Informant) Mrs Ella Bunn

(Address) 1226 N Eutaw St.

15- Filed ..... 192.. Robert F. Garrison, Burial Permit Clerk. Registrar.

DEC 13 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/12/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12 19.24, to Dec. 12, 19.24, that I last saw h.e.r. alive on Dec. 12, 19.24, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Aureus Septicemia

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bilateral Labial Abscesses.

(Duration) yrs. mos. 30 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 11/22/24

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Kenneth B. Boyd, M. D.

, 19 (Address) Womens Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cheltenville Chester Co Pa. DATE OF BURIAL, Dec 15 19.24

20-UNDERTAKER, Woolbrook ADDRESS

Via Penna R.R. — To Mrs Harry Lyons

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Dr Beach 2231 St Paul

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92899

CERTIFICATE OF DEATH.

4 D 92899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017. Edmondson ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Filora. Mayer.

(a) RESIDENCE NO. 2017. Edmondson ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christian Mayer.

6 DATE OF BIRTH (month, day, and year): June 6 1851.

7 AGE: Years 73. Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Fisco Augusta Eaton

(Address) 2017. Edmondson

15 Filed ..... 19 ..... Registrar

C 13 1924

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Dec 12, 1924.

that I last saw h[illegible] alive on Dec 12, 1924.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Leonard E Beach, M. D.

. 19 (Address) 2231 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Dec 15 1924

20 UNDERTAKER: [illegible] ADDRESS: 107 E. Monument.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eas.

D 92900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 92900

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 1526 Linden Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Howland McCoy

(a) Residence No. 1526 Linden Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin A. McCoy

6-DATE OF BIRTH (month, day and year) Apr 20 1846

7-AGE. 78 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Chas. Wesley Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mass

12-MAIDEN NAME OF MOTHER, Eliza Ann Sweetman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), At Sea

14- (Informant) Mrs. Annie R. Smith

(Address) 1526 Linden Ave.

15- Robert F. Harrison,

Filed 192.....

DEC 13 1924 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1920 to Dec. 11, 1924

that I last saw her alive on Dec. 10, 1924

and that death occurred, on the date stated above, at 9.55 a.m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) C. K. Shipley, M. D.

12-11, 1924 (Address) 11 20 E Pleasant

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park Cem	Dec 13, 1924
20-UNDERTAKER	**ADDRESS**
Wm Fickus Sons	North Pa

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9290I

CERTIFICATE OF DEATH.

D 9290I

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 12 WARD)

2-FULL NAME Harold V. Heyser Gertzig.

(a) RESIDENCE No. 431 E 22nd St ST., Balto WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 0 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. ~~Harold~~ Gertzig Clara V

6 DATE OF BIRTH (month, day, and year) Nov 20 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto driver.

(b) General nature of industry, business, or establishment in which employed (or employer) 123

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER Wm Gertzig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edith Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanoverown Md.

14 Informant Father Wm. Gertzig (Address) 431 E. 22nd St. Baltimore

15 Filed DEC 13 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924, to Dec 11, 1924, that I last saw h[illegible] alive on Dec 11, 1924, and that death occurred, on the date stated above, at 2:55 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Acute Nephritis.

(duration) yrs. 2 mos days.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? yes Date of Dec 3-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Operation

(Signed) E W Koons, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Dec 15 24
20 UNDERTAKER Wm J Pickney Sons.	ADDRESS North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 13 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92902

D 92902

CERTIFICATE OF DEATH.

T 188-81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Matthews.

(a) RESIDENCE NO. Glens Falls N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Blanche Matthews.

6 DATE OF BIRTH (month, day, and year) March 15,1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman for
(b) General nature of industry, business, or establishment in which employed (or employer) Chemical Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER William H.Matthews.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Margaret Wickes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Blanche Matthews.(wife)
(Address) 12 Nelson St.Glens Falls N.Y.

15 Filed DEC 13 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 12,1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Humerus, Ulna, Radius and Femur. Fall in a Car of Pa R.R.Co by by the sudden stop of the train, Accidental Death (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

Dec 12, 1924 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Accident Dec,4,1924 near Trenton,N.J.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hudson Falls N.Y. DATE OF BURIAL 12/15 1924

UNDERTAKER Wm J Tomlinson ADDRESS Hudson Falls N.Y.

Spec.—1-10-21—M&T—1500 Blks.

D 92903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92903

REGISTERED NO. 74901

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2058 Woodberry Ave. ST., 13 WARD)

2-FULL NAME William J. Stephens

(a) RESIDENCE NO. 2058 Woodberry Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Camill Stephens

6 DATE OF BIRTH (month, day, and year) March 14-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Joseph L. Stephens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Amanda Steele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Camill Stephens

(Address) 2058 Woodberry Ave

15 Filed DEC 13 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1924

17

I HEREBY CERTIFY, That I attended deceased from August 1, 1924, to Dec 11, 1924, that I last saw him alive on Dec 11, 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Nephritis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Sherman Robt. Wantz, M. D.

12-11, 1924 (Address) 865 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 13 1924
20 UNDERTAKER Horace H. Burgee	ADDRESS 3631 Falls Rd.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92904

HEALTH DEPARTMENT—CITY OF BALTIMORE. D 92904

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Appleton ST., 16 WARD)

REGISTERED NO. 1594

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Shine

(a) RESIDENCE NO. 1107 Appleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 10-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.
	—	—	2	3 hrs. 30 min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dallas (State or country) Tex.

PARENTS

10 NAME OF FATHER Joseph J. Shine

11 BIRTHPLACE OF FATHER (city or town) Kirkwood (State or country) Mo.

12 MAIDEN NAME OF MOTHER Mary Piemenezade

13 BIRTHPLACE OF MOTHER (city or town) Cauterets (State or country) France

14 Informant Joseph J. Shine (Address) 1107 Appleton St.

15 Dec 13 1924 Robert F. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1924, to Dec. 12, 1924, that I last saw her alive on Dec. 12 -, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure. Baby cyanotic from birth.

(duration) - yrs. - mos 2 ds.

CONTRIBUTORY (Secondary) Congenital cardiac weakness (duration) - yrs. - mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 12/13 1924

20 UNDERTAKER Valley Road

ADDRESS 1318 Eighty

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 13 1924

Spec.—1-10-21—M&T—1500 Bks.

D 92905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92905

148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 13 ..... WARD)

2-FULL NAME Mathilda Packett

(a) RESIDENCE NO. 2437 Carlton Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Sylvan Packett

6 DATE OF BIRTH (month, day, and year) Dec 10 1899

7 AGE: Years 25 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Julius Carlan

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mathilda Carlan

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Ahron Lowenthal
(Address) 1390 W. Fath Ave

15 DEC 13 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1924, to Dec 12, 1924,
that I last saw h[illegible] alive on Dec 12, 1924,
and that death occurred, on the date stated above, at 2 40 P. m.
The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Dec 11, 1924 Cesarean Section
Was there an autopsy? No
What test confirmed diagnosis? clinical & lab.

(Signed) Isidore I. Frey, M. D.
Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Otsh Sholam Cemetery — DATE OF BURIAL: Dec 14/1924

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 3314 Pan[illegible] Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3242 Foster Ave St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Drust

(a) Residence No. 3242 Foster Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1839-Jan 14

7-AGE: 85 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Jakob Kolodziej

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary Strowska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Catherine Manga

(Address) 3242 Foster Ave

15- DEC 13 1924 Robert T. Harrison, 192 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 11/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1924 to Dec. 11, 1924

that I last saw her alive on Dec. 11, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Myocardial Syph.)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Diffuse Scler. Thyroid.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Kaufowski M. D.

, 19 (Address) 3529 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St Stanislaus Cem	Dec 15, 1924
20-UNDERTAKER,	ADDRESS
Stephen Stalkowski	1028 S Kenwood Ave

DEC 13 1924

Make all entries EXACTLY. PHYSICIANS should state CAUSE OF DEATH fully. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92907

CERTIFICATE OF DEATH.

D 92907

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 E. Balto. St ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Bush

(a) RESIDENCE NO 224 N. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Bush

6 DATE OF BIRTH (month, day, and year) Jan 10/1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sol Grossfeld

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Liuinia Ennels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Foster
(Address) 1813 Orleans St

15 Filed DEC 13 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

Dec 12 24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodberry Cemetery — DATE OF BURIAL: Dec 14 1924

20 UNDERTAKER: Edward Bryan — ADDRESS: 671 Orleans St

IMPORTANT: AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 92908

CERTIFICATE OF DEATH.

10 D 92908

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 76 WARD)

2-FULL NAME William Boant Noel

(a) RESIDENCE NO. 3225 Fait Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 18. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Norman Noel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Catherine Rowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mother (Address)

15 Filed ..... 19... Robert F. Harrison, Registrar

C 1 31924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1924, to Dec 12, 1924, that I last saw him alive on Dec 12, 1924, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopay? No

What test confirmed diagnosis? Positive Culture

(Signed) Myron A. Dull, M. D.

12/13/24 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec 13 19 24
20 UNDERTAKER	**ADDRESS**
Zirkler & Zirkler	1731 E. Lex

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92909

CERTIFICATE OF DEATH.

159 D 92909

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 609 N. Bradford ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E Evans.

(a) RESIDENCE. NO. 609 N. Bradford. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 Minutes mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12-1924

7 AGE — Years — Months — Days — If LESS than 1 day hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William H Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Evelyn Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William H Evans

(Address) 609 N Bradford St

15 Filed DEC 13 1924 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12-24

17 I HEREBY CERTIFY, That I attended deceased from 12-12, 19 24 to 12-12, 19 24, that I last saw h[illegible] alive on 12-12-24 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Tumor of Tech Hemorrhage of Lumbar Cord

(duration) hrs. min.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gordon & Red Reaction

(Signed) [illegible] M. D.

19 (Address) 8008 Bath Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 13 1924
20 UNDERTAKER	ADDRESS
Jas E Mullenston	2334 Jeffer[illegible] St

DEC 13 1924

REGISTERED—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92910

CERTIFICATE OF DEATH.

1625 92910

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1915 Druid Hill Ave ST. 14 WARD)

2-FULL NAME No name, Baby Brown

(a) RESIDENCE. No. 1915 Druid Hill Ave, ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred half hour. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Newborn Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 - 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.
about 30 Minutes	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Alexander Brown

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Marie Stafler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Alexander Brown
(Address) 1915 Druid Hill Ave

15 Filed DEC 31 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1924

I HEREBY CERTIFY, That I attended deceased from Dec 10 - 10.30 A.M. 1924, to Dec 10 - 11 P.M. 1924, that I last saw h.r alive on Dec. 10 - 1924 and that death occurred, on the date stated above, at 11 - P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. about One hours mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) Not Known yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? no Date of operation

Was there an autopsy? no

What test confirmed diagnosis? Clinical only.

Signed J. Bunnell Fargo. M. D.

12/11. 1924 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cem.	Dec 13 1924

20 UNDERTAKER Samuel Handley ADDRESS 578 N Eutaw St

DEC 31 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92911

D 92911

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Bounty Lane ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Taylor

(a) RESIDENCE NO. 1423 Bounty Lane ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of George Washington Taylor

6 DATE OF BIRTH (month, day, and year) July 3, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress (Housework)

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Boud

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown Maryland

12 MAIDEN NAME OF MOTHER Fannie Boud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Frank P. Gibbs 1421 Bounty Lane

15 DEC 13 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924, to Dec 10, 1924, that I last saw her alive on Dec 8, 1924, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Regurgitation

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Bernard Harris, M. D.

, 19 (Address) 8 S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Dec 13 1924
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1526 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—state
mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important See instructions on

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92912

CERTIFICATE OF DEATH.

REGISTERED NO. 161-0

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2565 Oak St. ST., 17 WARD)

2-FULL NAME Baby Banks

(a) RESIDENCE NO. 2565 Oak St ST., ... WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: col

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years ... Months ... Days ... If LESS than 1 day 19 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: col

(b) General nature of industry, business, or establishment in which employed (or employer): col

(c) Name of employer: col

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Banks Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va Virginia

14 Informant (Address): JOHNS

15 FILED DEC 13 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th 1924 to Dec 11 1924, that I last saw h[illegible] alive on Dec 11 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Physical condition of mother and premature Birth

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Physical condition

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Ted Hale, M. D.

, 19 (Address) 1626 23 East

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: DEC 13 192[illegible]

20 UNDERTAKER: [illegible] Commissioner Health, ADDRESS

For Wm. F. Tyrrell

...—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92913

D 92913

CERTIFICATE OF DEATH.

1-79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Johnson

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Cold	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
about 50 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 040

9 BIRTHPLACE (city or town) Unknown
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant S. N. Dist
(Address) Robert F. Harrison, Johns Hopkins Hospital

Filed OCT 3 1924, 192 Burial Permit Clerk
(Date) Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry.)
thereon and from the evidence obtained ... find that said deceased came to ... death
(Inquest, Autopsy or Inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows: Accidentally burned by fire. This man went in a vacant house on West Baltimore St. & started a fire to warm by. Clothing caught fire. Thos. J. Horton, M. D.
Coroner.
Dec 11 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Boarders) At place of death ... yrs., ... mos., ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death? Burned Nov 19/24 Died Nov 29-24

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 13 1924

20 UNDERTAKER Commissioner Health. ADDRESS

FOR WM. R. WOOLFOLK

...mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... -TION is very important. See instructions on ...

GE should be stated EXACTLY. PHYSICIAN ... should state ... at it may be properly classified. Exact statem... OCCUPA- ... on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92914

100-091

1-PLACE OF DEATH

City of BALTIMORE: (No. 1030 Hillen Street St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Glorioso

(a) Residence No. 1030 Hillen Street St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Santa Glorioso

6-DATE OF BIRTH (month, day and year): 11/9/ 1864

7-AGE: 60 yrs. 1 mos. 3 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Italy

PARENTS.

10-NAME OF FATHER: Grackino Glorioso

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14- (Informant) Santa Glorioso
(Address) 1030 Hillen Street.

15- Filed 12/24 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 12 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 9/ 24 19.. to Dec 12 19.. 24

that I last saw h.. alive on Dec 12 19.. 24

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

broncho-pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) chronic bronchitis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Testa M. D.

12/13. 19 24 (Address) 100 Park Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: 12/15/ 19.24

20-UNDERTAKER: George J Ruth ADDRESS: 1735 HARFORD AVE.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF D... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import... instructions on back of certificates. See

Spec.—1-10-21—M&T—1500 Bks.

1766 40

D 92915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001

D 92915

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 7 ST., WARD)

2-FULL NAME Charles A Harris

(a) RESIDENCE NO. Norton Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha

6 DATE OF BIRTH (month, day, and year): ? ? ?

7 AGE: Years 28 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gen Owner of

(b) General nature of industry, business, or establishment in which employed (or employer): Bus. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Andy Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed DEC 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 2 -, 1924, to Dec 12 -, 1924.

that I last saw h~~e~~ alive on Dec 12 -, 1924,

and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Fistula in Ano.

(duration) yrs. 3. mos. ds.

18 Where was disease contracted if not at place of death? Norfolk Va

Did an operation precede death? Yes Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis?

(Signed) J A Wesenberg, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk Va — DATE OF BURIAL: 11/14 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 92916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92916

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Church Home and Infirmary St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Lennie Bonney

(a) Residence No. No 4 West End Apt St. Norfolk Virginia Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. -- mos. 15 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. 62 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Norfolk Va.

PARENTS:

10-NAME OF FATHER: ------- Bonney

11-BIRTHPLACE OF FATHER (city or town) (State or Country): P.A.Co. Va.

12-MAIDEN NAME OF MOTHER: Elizabeth P. Henley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): P.A. Co. Va.

14- (Informant) Jesse T. Bonney

(Address) St. Petersburg, Fla.

15- Filed DEC 14 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/13/24

17- I HEREBY CERTIFY, That I attended deceased from 11/28/24 19 24 to December 13 19 1924 that I last saw h. Ex alive on December 13 19 24 and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. W. Saunders M. D

, 19 (Address) Church Home & Inf.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk, Va. DATE OF BURIAL: 12/14 19 24

20-UNDERTAKER: Henry W. Mears & Son ADDRESS 805 E. Calvert

Via Old Bay Line - J. T. Bonney - Norfolk Va. - Escort.

Fill in all items accurately. Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 92917 M

Coroner Potter has been notified D 92917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD) 6th

2-FULL NAME Harry Cooper

(a) RESIDENCE No. 512 S. Hanover ST., ... WARD Dec 13/24

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal 034

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sarah Cooper

(Address) 512 S Hanover st

15 Filed DEC 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924 to Dec. 12, 1924

that I last saw him alive on Dec. 12, 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Chr. bronchitis. arteriosclerosis

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor L. Fry M. D.

Dec, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	12/14 1924
20 UNDERTAKER Jos Levinson & Bro	ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 D. 92918

D. 92918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 3 ST., Lee WARD 6)

2-FULL NAME Harris Brewer

(a) RESIDENCE NO. 260 S. Spring ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Pavle Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Makrover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rose Brewer
(Address) 260 S Spring st

15 Filed DEC 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1924, to Dec. 12, 1924, that I last saw him alive on Dec. 1st, 1924, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Uraemia (syphilis) 1 yr.

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Arteriosclerosis; myocarditis

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor D. Levy, M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery Co. DATE OF BURIAL 12/14 1924

20 UNDERTAKER Sol Levinson & Bro ADDRESS 12 E Balto St

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 92919 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 100-001 D 92919

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. Bay View Hosp St., 5 Ward)

2-FULL NAME Morris Goldstein, Morris Goldstein

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1117 E. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~, HUSBAND of (or) ~~WIFE~~ of Rose Goldstein

6-DATE OF BIRTH (month, day and year) 1877

7-AGE 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-(Informant) Jack Lewis

(Address) 1439 E Baltimore St

15-

Filed 192

DEC 14 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/13/24

17- I HEREBY CERTIFY, That I attended deceased from 12/1/ 19 24 to 12/13/ 19 24

that I last saw h~~im~~ alive on 12/31/ 19 24

and that death occurred, on the date stated above, at 9 40 a m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(Duration) yrs. mos. ds.

18-Where was disease contracted ? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical diagnosis.

What test confirmed diagnosis?

(Signed) H. L. Goldsmith M. D.

12/13 19 24 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 12/14 19 24

20-UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-001.
D 92920

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2300 Auchentoroly Terrace St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Blumberg

(a) Residence No. 2300 Auchentoroly Terrace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Beatrice Blumberg

6-DATE OF BIRTH (month, day and year)

7-AGE 62 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Aller Blumberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Yentl Blumberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Aller Blumberg

(Address) 220 N Linden Ave.

15- Filed. DEC 14 1924 Bur. ROBERT R. REACH Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/13/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 19 24 to Dec 13th 19 24

that I last saw h. alive on Dec 13th 19 24

and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Splenomegalic Leukemia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Pulmonary Edema

(Duration) yrs. 1 mos. 2 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Michael N. Abrams M. D.

Dec 13, 1924 (Address) 1360 Eutaw Place.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Hebrew Rest DATE OF BURIAL, 12 Dec 19 24

20-UNDERTAKER, Jack Levin ADDRESS 1439 Eutaw St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 146 D 92921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Shacklett

(a) RESIDENCE NO. Eccleston, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Claude Shacklett

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1888

7 AGE: Years 36; Months; Days 8; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 10 01

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER John Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Mary Beall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Claude Shacklett (Address): Eccleston, Md

15 Filed ... 19 ... Registrar

DEC 1 1924 ROBERT P. KRAUS

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-6, 1924, to 12-13, 1924, that I last saw her alive on 12-13, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal infection

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Family Ballo Cem. — DATE OF BURIAL: Dec 15 1924

20 UNDERTAKER: Charles H. Alexander — ADDRESS: 1401 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

Examiner 1013 Prof. Ave

D 92922

92922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 743 Wash. Boulevard 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Ritter

(a) Residence No. 743 Washington Blvd St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph C.

6-DATE OF BIRTH (month, day and year) Dec 7 1855

7-AGE. 69 yrs. mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore

PARENTS

10-NAME OF FATHER, Wm Simmel

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Rebecca Shelton

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Baltimore

14-(Informant) J. G. McLaughry

(Address) 743 Wash Blvd

15-DEC 14 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Dec 12 1924

that I last saw her alive on Dec 11 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Paraplegia Agitans

(Paralytic Period)

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Walter Sampley M. D

, 19 (Address) 2813 Poplar Grove

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Dec 15 1924

20-UNDERTAKER. Wm Corkran ADDRESS 511 E Fayette

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92923

CERTIFICATE OF DEATH.

100-001 D 92923

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ellen Hathaire Poulson

(a) Residence No. 2439 Francis St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Poulson

6-DATE OF BIRTH (month, day and year) Jan 1 1846

7-AGE. 78 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Denmark
(State or Country).

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Denmark

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country), Denmark

14- (Informant) Municipal Hospital Records

(Address).....

15- DEC 14 1924 ROBERT R. KRAUSE, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-13-24

17- I HEREBY CERTIFY, That I attended deceased from 2-3....., 1921, to 12-13., 1924 that I last saw h.. alive on 12-12., 1924 and that death occurred, on the date stated above, at 4.20 a. m. The CAUSE OF DEATH* was as follows:

Senile Deterioration

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

.....(Duration).....yrs.....mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Ob

(Signed) Claude E. Drane, M. D.

12-13-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn	Dec-15 1924
20-UNDERTAKER. W. M. Cook	ADDRESS 502 E Fort Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92924

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

18 129

D 92924

Registered No.....

City of BALTIMORE: (No. 121 Scott St., ... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ..... Henry Spence,

(a) Residence No. 121 Scott St. ..... St., ... Ward

(Usual place of abode) 45

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Spence

6-DATE OF BIRTH (month, day and year) Mar 10. 1838

7-AGE. 86 yrs. 9 mos. 3 ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Laborer (Gen'l)

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer .....

9-BIRTHPLACE (City or town) (State or Country). Harford Co, Md

PARENTS.

10-NAME OF FATHER. John Spence

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Harford Co Md

12-MAIDEN NAME OF MOTHER. Doris Lyons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Harford Co, Md

14-

(Informant) ..... Sarah Spence

(Address) ..... 121 Scott St

15-

Filed DEC 14 1924 ..... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 13th. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1924 to Dec. 13th. 1924

That I last saw h-im alive on Dec. 13th. 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ----------

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Urine Analysis Etc.

(Signed) Chas Norton, M. D.

12/13/24 (Address) 888 N. Eutaw St

* State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harford Co Cem Co Harford	12/15 1924
20-UNDERTAKER. Wm Cook	ADDRESS 502 E. Fayette

am

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Exact statement of OCCUPATION is very important. See

CAUSE OF DEATH

D A K S · A F E

Spec. 1-10-21—M&T—1500 Blks.

292925

HEALTH DEPARTMENT—CITY OF BALTIMORE

292925

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2664 Dulaney ST., 20th WARD)

2-FULL NAME Katie E. King

(a) RESIDENCE No. 2664 Dulaney ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos E. King

6 DATE OF BIRTH (month, day, and year): June 20 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
41	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): -

(c) Name of employer: -

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Nicholas Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt. Md

12 MAIDEN NAME OF MOTHER: Mary Linell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Thos E. King

(Address) 2664 Dulaney

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13th 1924

17 I HEREBY CERTIFY, That I attended deceased from 22 Nov 1924 to 13 Dec 1924,

that I last saw h[illegible] alive on 13 Dec 1924,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

General Paresis.

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Gen. Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Z. Hamilton Foster, M. D.

1924 (Address) 2565 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 16 1924

20 UNDERTAKER: F B Kyle — ADDRESS: 1850 N. Bond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92926

CERTIFICATE OF DEATH.

101-001 D 92926

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 501 N. Bel Air Road

CITY OF BALTIMORE: (No. Raspe burg Balto. Md ST., 26th WARD)

2-FULL NAME Rhoda Rebecca Brice

(a) RESIDENCE No. 501 N. Bel Air Rd. ST., 26th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Clifford T. Brice

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George H. Bausman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Swem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clifford T. Brice (Address) 501 N. Bel Air Rd. Raspeburg

15 Filed DEC 14 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1924 to Dec. 12, 1924.

that I last saw her alive on Dec. 12, 1924.

and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia with Pleurisy effecting both lobes of left lung

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

12/14, 1924 (Address) 13 N. Bel Air Rd. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Cemetery	Dec 15 1924
20 UNDERTAKER	ADDRESS
Fred K Lassahn Sons	Fullerton

Burial Permit

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 92927

1-PLACE OF DEATH — REGISTERED No. 92927

CITY OF BALTIMORE (No. 2917 Winchester St 57 ST 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Hergel

(Residence in Baltimore: No. 2917 Winchester St. Lyds. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: January 16, 1855 (Month) (Day) (Year)

7 AGE: 69 yrs. 10 mos. 25 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Lindner

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Gerdes

(Address): 2917 Winchester st

15

Filed ..., 191... ROBERT B. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 12, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1923 to Dec 12, 1924, that I saw h[illegible]e on Dec 11, 1924, and that death occurred, on the date stated above, at 3, 00 m.

The CAUSE OF DEATH* was as follows:

Cholera

(Duration) 10 yrs. mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) yrs. 11 mos. 2 ds.

(Signed) Ira V Gelbert M. D.

12/14, 1924 (Address) 2724 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem — DATE OF BURIAL: 12/15, 1924

20 UNDERTAKER: Wm A Foley — ADDRESS: Funeral Director

Spec.—1-10-21—M&T—1500 Bks.

D 92928

Sears.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92928

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sears Jr.

(a) RESIDENCE NO. 138 Wilkins St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William Sears

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Sheppard

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs William Sears
(Address) 138 Wilkins St.

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1924, to Dec 12, 1924, that I last saw him alive on Dec 12, 1924, and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute gastro enteritis.

(duration) 0 yrs. 0 mos 5 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) 0 yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 15 1924
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Broa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

92929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 12 D 92929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Parsons

(a) RESIDENCE NO. Watson, Kent Co ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	66	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Morrisville Pa
(State or country)

PARENTS

10 NAME OF FATHER Isaac Parsons

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Hospital Record
(Address)

15 Filed DEC 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/12/24

17

I HEREBY CERTIFY, That I attended deceased from 11/26/24, 19..., to 12/12/24, 19...,
that I last saw h... alive on 12/12/24, 19...,
and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Emphysema Gall Bladder

Pancreatitis Hemorrhagic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2 Towns for Orange

Did an operation precede death? No. Date of 12/11/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) K. W. Galloway, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Rural	Dec 15 1924
20 UNDERTAKER Jos Jacobsen & Son	ADDRESS 217 S. Pa...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92930 — 91-002 — D 92930

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 923 E. Lombard St. 2D WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Goodman

(a) RESIDENCE No. 923 E. Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Sekel Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Ikagl Goodman (Address) 923 E. Lombard St

15 Filed ..., 19.. ROBERT P. KRAUTER, Registrar

DEC 14 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13/1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1924, to Dec 13th, 1924, that I last saw him alive on Dec 13th, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Heart Disease

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Steinberg, M. D.

12/13/1924 (Address) 2302 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	12/14/1924

20 UNDERTAKER David Sondheim — ADDRESS 1125 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

92931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X100-001 D 92931

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mrs. Hope Retreat St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Catherine Wallace

(a) Residence No. Mrs. Hope Retreat St., Ward. Cumberland Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Jan. 2. 1848

7-AGE, 76 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Edward Barrett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Nancy McKoy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Scotland

14- (Informant) Mrs. Hope Retreat

(Address) Mrs. Hope Retreat

15- Filed. 192 By: Registrar.

DEC 14 1924 ROBERT R. KRAUTER
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 13 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Dec 13, 1924, that I last saw h. alive on Dec 13, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Senility

Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walton F. Hall, M. D.

, 19 (Address) Keyser Bldg. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount — DATE OF BURIAL, 1 [illegible] 24

20-UNDERTAKER, [illegible] — ADDRESS [illegible]

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 92932 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 92932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 N. Mount St. 15 WARD)

2-FULL NAME Mary Eliza Hughes

(a) RESIDENCE. NO. 1503 N. Mount St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marshall Hughes

6 DATE OF BIRTH (month, day, and year) April 20 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Beaverdam
(State or country) Va.

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) Beaverdam
(State or country) Va.

12 MAIDEN NAME OF MOTHER Josephine Knight

13 BIRTHPLACE OF MOTHER (city or town) Beaverdam
(State or country) Va.

14 Informant Nannie Hughes Haines
(Address) 1505 N. Mount St.

15 Filed ..... 19 .....

DEC 14 1924 ROBERT R. KRAUSE, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1924, to Dec 11, 1924, that I last saw h[illegible] alive on Dec 10, 1924, and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Wright, M. D.

Dec 11, 1924 (Address) 1209 Park Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec 15 1924
20 UNDERTAKER Wm R. C. Elliott	ADDRESS 1715 Linden Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92933

CERTIFICATE OF DEATH.

44 D 92933

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 5 WARD)

2-FULL NAME William Campbell

(a) RESIDENCE NO. Severing House ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? Unknown ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Sailor 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record.

(Address)

15 Filed DEC 14 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8/24

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 19 24 to Dec 8, 19 24

that I last saw h[illegible]ive on 12/8/24, 19 and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows: Gastric Carcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. W. Hedley M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL 12/14 19 24

20 UNDERTAKER John F. Lakenhouse — ADDRESS 318 Eighth St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92934

CERTIFICATE OF DEATH. 185

D 92934
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Ailsa Avenue, ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Ann Rohrer,

(a) RESIDENCE No. Keedysville, Washington County, Maryland. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jacob C. Rohrer.

6 DATE OF BIRTH (month, day, and year) November 30, 1837.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife, retired 4 yrs., 10 mos., 28 ds.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eakle's Mill, Washington County, Maryland.

PARENTS

10 NAME OF FATHER Simon Wyand.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eakle's Mill, Maryland.

12 MAIDEN NAME OF MOTHER Rebecca Leeting.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Keedysville, Maryland.

14 Informant Dr. C. W. G. Rohrer (son).
(Address) 22 Ailsa Ave., Baltimore, Md.

15 Filed DEC 14 1924 ROBERT N. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 13, 1924.

17 I HEREBY CERTIFY, That I attended deceased from November 24, 1924, to December 13, 1924, that I last saw her alive on December 9th, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Dislocation of right hip due to a fall, shock and Exhaustion,

(duration) 0 yrs. 0 mos 19 ds.

CONTRIBUTORY (Secondary) arterio-sclerosis and senile dementia, (duration) 5 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? At place of death, and Keedysville, Md.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) Claud Summy M. D.

12/12, 1924 (Address) 4702 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keedysville, Washington Co., Md.	Dec. 16, 1924
20 UNDERTAKER Wm. H. Smith Funeral Co.	ADDRESS 1791 N. Arch St. Keedysville, Md.

(Over)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 D 92935

CERTIFICATE OF DEATH.

X 118-002

D 92935

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Leon Salzburg

(a) RESIDENCE NO. 1013 Holt St Norfolk Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Salzburg

6 DATE OF BIRTH (month, day, and year) Dec? 1868(?)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) " 86

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Rev. Benj. Siegel

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Reeva

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Record

(Address) JOHNS HOPKINS HOSP.

15 DEC 15 1924

ROBERT R. KRAMER, Registrar

Daniel Purcell Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924 to Dec 13 1924.

that I last saw h alive on Dec 13 1924.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Pneumonia secondary (Bronchial)

Pulmonary Embolism

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec 12 Release of Intestinal Obstruction

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Thos Harrold M. D.

12/14 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL 12/14 1924

20 UNDERTAKER Wm Rinson & Bro — ADDRESS 1127 E Baltimore St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92936

X 181-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Wingfield Ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Alma Starbuckner

(a) RESIDENCE NO. 3210 Wingfield Ave ST., ... WARD Kentucky

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Starbuckner

6 DATE OF BIRTH (month, day, and year) Aug. 31 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	24	3	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10 NAME OF FATHER Wm. H. Bostaun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Frances Shumate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant Harry Starbuckner
(Address) 3210 Wingfield Ave

15 DEC 15 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas.

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) accidental (Gas stove)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 14, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louisville Kentucky	Dec 15 1924
20 UNDERTAKER	ADDRESS
Josiah Syfer	1606 W. Main Ave

BURIAL PERMIT ISSUED

ROBERT P. KRAUSE
REGISTRAR OF VITAL STATISTICS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 92937 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 92937

CERTIFICATE OF DEATH. X 181-001

1-PLACE OF DEATH West Balto. Gen'l Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 3210 Winfield Ave. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Starkweather

(a) RESIDENCE NO. 3210 Winfield Ave. WARD Kentucky
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14, 192[illegible]

7 AGE Years 1 Months 8 Days 30 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10 NAME OF FATHER Harry C. Starkweather

11 BIRTHPLACE OF FATHER (city or town) (State or country) Colorado

12 MAIDEN NAME OF MOTHER Alma Barbour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant Harry C. Starkweather (Address) 3210 Winfield ave.

15 Filed DEC 5 1924, 192 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas.

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) accidental (gas inhal)

(duration) yrs. mos. da.

(Signed) J. J. Hennessy, M. D. (Coroner)

Dec. 14, 1924 (Address) 2[illegible] Monument

*State The Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., da. In the State yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louisville Kentucky — DATE OF BURIAL Dec 15 1924

20 UNDERTAKER Josiah Syfer — ADDRESS 1605 W Balto ave

BEFORE WRITING, READ CAREFULLY. NAME should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

OKD 92938
A K Gorsuch

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92938

CERTIFICATE OF DEATH.

+ 185 corrected dit

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2-FULL NAME Herbert Hefsley

(a) RESIDENCE NO. Marriottsville, Howard Co. - Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Hefsley

6 DATE OF BIRTH (month, day, and year): Jan. 3, 1888

7 AGE — Years: 36 — Months: 11 — Days: 14 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Works for self.

9 BIRTHPLACE (city or town) (State or country): Marriottsville, Howard Co. Md

PARENTS

10 NAME OF FATHER: John Hefsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Marriottsville Howard Co. Md

12 MAIDEN NAME OF MOTHER: Jennie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ellicott City Howard Co Md

14 Informant (Address): University Hospital

15 Dec 15 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924, to Dec 14, 1924, that I last saw him alive on Dec 14, 1924, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

(a) Pulmonary edema

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

Chronic nephritis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Marriottsville Howard Co.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Andersen, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Spring Field Cem

DATE OF BURIAL: Dec. 16. 1924

20 UNDERTAKER: Edwards Woodyear

ADDRESS: Sykesville Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1066

92939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+131

D 92939

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Johnston

(a) RESIDENCE NO. Box 3 Warrows Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (Write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 43 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): — 062

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Isaac Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elmira Southall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed OCT 15 1924 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 - , 1924 to Dec 13 , 1924, that I last saw him alive on Dec 13 , 1924, and that death occurred, on the date stated above, at 11 48 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
Pyelo-nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Perforated duodenal ulcer (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 12/3/24

Was there an autopsy? Yes

What test confirmed diagnosis? Yes.

(Signed) Thomas Harrold, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Warrows Va — DATE OF BURIAL 11/14 1924

20 UNDERTAKER: Joseph Ahrens — ADDRESS 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92940

CERTIFICATE OF DEATH.

7 45 D 92940

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hos. ST., 7 WARD)

2-FULL NAME Theodore Frank Appleby

(a) RESIDENCE No. 901 Grand Av. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Asbury Park N.J.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice Hoffman Appleby

6 DATE OF BIRTH (month, day, and year) Oct 11 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
60		2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Congressman
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Theodore F. Appleby

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Margaret Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J.

14
Informant Hospital Records
(Address)

15
Filed DEC 15 1924 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1924

17
I HEREBY CERTIFY, That I attended deceased from Dec 5 . 1924 . to Dec 15 . 1924.
that I last saw h alive on Dec 15 . 1924.
and that death occurred, on the date stated above, at 12.35 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum
Cardiac failure

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
Cardiac failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? yes Date of Dec 6
Colostomy
Was there an autopsy? yes
What test confirmed diagnosis? Partial Autopsy
(Signed) Hugh Hampton M. D.
. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Park N.J. DATE OF BURIAL Dec 15 1924

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 92941

CERTIFICATE OF DEATH.

129 D 92941

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5107 Ferndale Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin J. Carpenter

(a) Residence No. 5107 Ferndale Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~ (Write ~~word~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Johnson Carpenter

6-DATE OF BIRTH (month, day and year) Apr. 23 1851

7-AGE, 73 yrs. 7 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware dealer

(c) Name of employer self

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER Charles Carpenter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Jane V. Hicks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. Y.

14- (Informant) Aubrey Carpenter

(Address) 5107 Ferndale Ave

15- Filed DEC 15 1924 ROBERT R. KRAUTH, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 13. 24

17- I HEREBY CERTIFY, That I attended deceased from May 21 1921 to Dec 13 1921

that I last saw h ill alive on Dec 12 1924

and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Chronic nephritis, Cardiac weakness

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual routine

(Signed) W. E. Krumbhaar M. D.

12/13 1924 (Address) 1002 N. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 15 1924

20-UNDERTAKER John O. Mitchell — ADDRESS 1201 W. Fayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92942

CERTIFICATE OF DEATH.

D 92942

128

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1922 Wilkens Ave St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edgar Ellis

(a) Residence No. 1922 Wilkens Ave St., ... Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Color

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of (or WIFE of) Georgia Gozned Ellis

6-DATE OF BIRTH (month, day and year) June 17, 1867

7-AGE, 57 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Piano Tuner

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Georgia Ellis

(Address) 1922 Wilkens Ave

Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/12/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 3, 1924, to Dec 13, 1924, that I last saw him alive on Dec 12, 1924 and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. 30 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) M. J. Hamm, M. D.

Dec 13, 1924 (Address) 1822 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Johns Cemetery, Relay Md

DATE OF BURIAL, Dec 15, 1924

20-UNDERTAKER. Harry H. Witzke

ADDRESS 1531 W Lombard St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92943

CERTIFICATE OF DEATH.

159-002

D 92943

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Cherry St. Curtis Bay. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jcseph Bryl.

(a) RESIDENCE NO. 1 Cherry St. Curtis Bay. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 22, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	---	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Bryl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Gertrude Korecka.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia.

14 Informant Gertrude Bryl. (mother)
(Address) 1 Cherry St. Curtis Bay.

15 Filed DEC 15 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) December 13 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

Dec, 14, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. DATE OF BURIAL Dec 16 1924

20 UNDERTAKER Frank Crockson ADDRESS 1906 Eutaw Place

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92944

CERTIFICATE OF DEATH.

44 D 92944

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 E La Fayette St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Frankstick

(a) Residence No. 1917 E La Fayette St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

~~5-Single,~~ Married, ~~Widowed~~ or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Emma M. Frankstick

6-DATE OF BIRTH (month, day and year) Aug 9 1844

7-AGE, 80 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shelby Ice Co

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant) Mrs. Emma M. Frankstick

(Address) 1917 E La Fayette St

15- Filed DEC 5 1924 ROBERT R. KRAMER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/2/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 19 24, to Dec 2 19 24, that I last saw him alive on Dec 2 19 24, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward H. Cook M. D.

12/5, 19 24 (Address) 4 E Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL, Dec 6, 19 24

20-UNDERTAKER, John Lellis & Co ADDRESS 2008 Eden

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92945

CERTIFICATE OF DEATH.

111-002 D 92945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2922 E Monument ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edward Barnickel

(a) RESIDENCE NO. 2922 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M Barnickel

6 DATE OF BIRTH (month, day, and year) June 1st 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John F Barnickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dora Barnickel

(Address) 2922 E. Monument

15 Filed DEC 5 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1924, to Dec. 13, 1924, that I last saw him alive on Dec. 13, 1924, and that death occurred, on the date stated above, at 8:05 A. m.

The CAUSE OF DEATH* was as follows:

Sub-diaphragmatic abscess

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Duodenal ulcer

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes - confirming

What test confirmed diagnosis? above diagnosis.

(Signed) Grant Edwards, M. D.

, 19 (Address) 1418 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Dec 17 1924

20 UNDERTAKER John Merrick

ADDRESS 20 E Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92946

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 92946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 504 S. 13th St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Henry Rehak

(a) Residence No. 504 S. 13th St., No Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 11-1924

7-AGE, — yrs. — mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Steve Rehak

11-BIRTHPLACE OF FATHER (city or town)..... Hungary Balto Co
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Ditz

13-BIRTHPLACE OF MOTHER (city or town)..... Balto.
(State or Country), Md.

14-
(Informant)..... Steve Rehak
(Address)..... 504 S. 13th St.

15-
Filed DEC 15 1924 ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 11, 19 24 to Dec 14, 19 24

that I last saw him alive on Dec 13, 19 24

and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H B Tilson M. D.

12/15, 1924 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart. DATE OF BURIAL, Dec 15-4, 1924

20-UNDERTAKER, Tilly & Zeile ADDRESS 403 S. Wolfe St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92947

CERTIFICATE OF DEATH.

100-001

D 92947

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 935 S Paca. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elmer E. Cooper

(a) Residence No... 935 S Paca. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) Oct 4 1922

7-AGE, 2 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Fenby Cooper

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Helen Grisendaffer

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Balto Md

14- (Informant) Helen Cooper

(Address) 935 S Paca St

15- Filed..... 19?

RUBERT R. KRAUTER, Registrar.

Burial Permit Given.

DEC 19 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 13 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 8, 19 24, to Dec 13, 19 24

that I last saw h— alive on Dec 13, 19 24

and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)...yrs...mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration)...yrs...mos...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Hooker A Dunn M. D.

, 19 (Address) 127 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Park Cem Co. DATE OF BURIAL, 12-15 1924

20-UNDERTAKER, James Dignan Son ADDRESS 1000 S Paca St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49D 92948

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 3526 Parkdale Ave Ward) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin E. Fisher

(a) Residence No. 3525 Parkdale Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Sarah Fisher

6-DATE OF BIRTH (month, day and year) Oct 14 1846

7-AGE. 78 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer). 015

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Bertie Foreman

(Address) 3525 Parkdale Ave

15-

Filed DEC 15 1924 ROBERT P. KRAUS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12-24

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 24 to Dec. 12 19 24

that I last saw h... alive on Dec. 12 19 24

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Intestines Inverse

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) C. F. Humpdent M. D.

12/12. 19 24 (Address) 320 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Hampden — DATE OF BURIAL. Dec 15 19 24

20-UNDERTAKER Chas. Sonnewald Son — ADDRESS 3617 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-901

D 92949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1250 Spring St., West Port 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Buckley

(a) RESIDENCE NO. 1250 Spring ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Rosie Kay Stidham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mr Charles Buckley

(Address) 1250 Spring St.

15 Filed DEC 15 1924 ROBERT R. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1924 to Dec 13, 1924

that I last saw him alive on Dec 11, 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. S. Kieffer, M. D.

Dec 15, 1924 (Address) 232 N. Bond Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 15 1924
20 UNDERTAKER	ADDRESS
Percy Pegram & Son	
per J. J. Cowen.	Govans

IMPORTANT—THIS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92950

CERTIFICATE OF DEATH.

90 D 92950

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Holbrook ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Schnefer

(a) RESIDENCE NO. 1401 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Joseph J. Schnefer

6 DATE OF BIRTH (month, day, and year) Feb. 3rd 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Kirchner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs. Stengel 12-14 19 24 (Address) 1531 E. North Ave

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Joseph J. Schnefer
(Address) 1401 Holbrook St

15 Filed DEC 15 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 19 24

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 19 22, to Dec. 14, 19 24,
that I last saw he alive on Dec 13, 19 24,
and that death occurred, on the date stated above, at 4.40 a m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral regurgitation

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) V. V. Brumback M. D.

(Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Dec. 17 19 24

20 UNDERTAKER Henry Hoerdt Sons — ADDRESS 1301 E Eager St

N.B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92951

D 92951

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 E Eager St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry mrs Krueger

(a) Residence No. 1308 E Eager St., 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? 54 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of late Henry Krueger

6-DATE OF BIRTH (month, day and year) Nov 1851

7-AGE. 73 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS

10-NAME OF FATHER: Wm. Neuberger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mrs. Stoff.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-Informant: Mr. John Preuninger

(Address) 1602 N. Caroline St

15-Filed DEC 15 1924 HUBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 14th 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 11th 24 to Dec 14th 1924

that I last saw h... alive on Dec 14th 1924

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cause Known Definitely

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) ... yrs. ... mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Loyer M. D.

Dec 15 1924 (Address) 501 E Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — DATE OF BURIAL: Dec 17 1924

20-UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92952

CERTIFICATE OF DEATH.

3 | D 92952

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 So. Highland Ave ST., 76 WARD)

2-FULL NAME Frank Bishop Rhinehart

(a) RESIDENCE NO. 201 So. Highland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Umbrella Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Sigel & Rothschild

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Rhinehart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Kolb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward E. Rhinehart

(Address) 201 So. Highland Ave

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 8 '24 to Dec 12 '24

that I last saw he alive on Dec 12 1924

and that death occurred, on the date stated above, at 1 20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Arthur Insley, M. D.

12-13 1924 (Address) 2938 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wake Lawn Dec. 15 - 1924 DATE OF BURIAL

20 UNDERTAKER H. M. Corkran & Sons ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92953

CERTIFICATE OF DEATH.

3 1 V

D 92953

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Asylum ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Heil

(a) RESIDENCE NO. 133 S. 1st St. ST Brooklyn, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Heil

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bartender

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto Md.
(State or country) United States

PARENTS

10 NAME OF FATHER not obtained

11 BIRTHPLACE OF FATHER (city or town) not obtained
(State or country)

12 MAIDEN NAME OF MOTHER not obtained

13 BIRTHPLACE OF MOTHER (city or town) not obtained
(State or country)

14 Informant Records
(Address) Bay View Asylum

15 Filed DEC 15 1924, 19 ROBERT R. KRAMER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Dec. 13, 1924; that I last saw h (m)alive on Dec. 13, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. White, M. D.

, 19 (Address) Bay View Asylum

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cem.	12/16 1924
20 UNDERTAKER	**ADDRESS**
J. Fenwick Mullikin	130 E. Fort

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92954

CERTIFICATE OF DEATH.

129

D 92954

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. U. S. Marine Hosp. #1 ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F Thomas

(a) RESIDENCE NO. 910 E. Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah E Thomas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Greenbag Johnson Lumber Co.

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Thomas J. Thomas

(Address) 110 E. Montgomery St.

15 Filed DEC 15 1924 ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1924

17

I HEREBY CERTIFY, That I attended deceased from December 12, 1924, to December 13, 1924, that I last saw h unalive on December 13, 1924, and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

uremic poisoning

H. Coroner J. Donnelly

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic parenchymatous nephritis

8 Mitral insufficiency (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Laboratory~~ Clinical findings

(Signed) M. H. Feder M. D.

19 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Dec 15 1924

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St.

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 92955

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Druid Hill Av ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mealey

(a) RESIDENCE NO. 807 Druid Hill Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, ~~or divorced~~,
HUSBAND of
(or) ~~WIFE~~ of Frances Mealey

6 DATE OF BIRTH (month, day, and year) Dec 27 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	88	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of Industry, business, or establishment in which employed (or employer) Private waiter

(c) Name of employer —

9 BIRTHPLACE (city or town) Hall Springs
(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Frederick Mealey

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Henrietta Distance

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) A.A. County Md

14 Informant Henrietta Jefferies
(Address) 807 Druid Hill Av

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1924, to Dec 12, 1924, that I last saw him alive on Dec 7th, 1924, and that death occurred, on the date stated above, at 12 45 ~~P~~ A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) — yrs. — mos 24 ds.

CONTRIBUTORY (Secondary) Cardiac Weakness (duration) — yrs. — mos. 24 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward Engelmeyer, M. D.

12/13 1924 (Address) 1339 W North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem — DATE OF BURIAL Dec 16 24

20 UNDERTAKER Samuel B Hensley — ADDRESS 1378 N Bdle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 92956

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 842 N Carey St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T Mason

(a) Residence No. 842 N Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie A Mason

6-DATE OF BIRTH (month, day and year) Jan 26 1876

7-AGE. 48 yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Peter Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Annie A Mason

(Address) 842 N Carey St

15- Filed DEC 15 1924 ROBERT R. KRAUTH Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/11/24

17- I HEREBY CERTIFY, That I attended deceased from 12/3, 1924 to 12/11 1924

that I last saw h. Wife alive on 12/11 1924

and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchym. Nephritis

(Duration) yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 9 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H S McCaul M. D.

12/12 1924 (Address) 1008 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem | DATE OF BURIAL. Dec 15 1924

20-UNDERTAKER Samuel Hemsley | ADDRESS 1711 Madison Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92957

CERTIFICATE OF DEATH.

129 ✓

D 92957

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Raynor ave & Dukeland ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Harvey Blizzard.

(a) RESIDENCE NO. 1913 McKean ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Conlon

6 DATE OF BIRTH (month, day, and year) July 20/82

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Gas and Electric

(c) Name of employer Consolidated G & E Co Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Wm Harvey Blizzard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hampstead Carroll Co Md

12 MAIDEN NAME OF MOTHER Charlotte Louise Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Hatter Ward 3519 av L Brooklyn NY

DEC 15 1924

Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 14, 1924, that I last saw him alive on Dec 14, 1924, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uremia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically & Labratory

(Signed) Clement B. Morrell, M. D.

, 19 (Address) West Balto General Hospital Baltimore Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec 17th 1924

20 UNDERTAKER Josiah Leffler 1600 Harford ave

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92958

CERTIFICATE OF DEATH.

+ 181-001

D 92958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH West Balto. General Hosp.

CITY OF BALTIMORE: (No. ~~Carey and Hoop~~ ST., 15 WARD)

2-FULL NAME Doris Stockweather

(a) RESIDENCE No. 3014 Winfield Ave WARD Kentucky

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10 NAME OF FATHER Harry Stockweather

11 BIRTHPLACE OF FATHER (city or town) (State or country) Colorado

12 MAIDEN NAME OF MOTHER Alma Bachham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Harry Stockweather
(Address) 3014 Winfield Ave.

15 Filed DEC 15 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

asphyxiation by gas (accidental)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (gas stove)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Dec. 14, 1924 (Address) 2802 Edgewood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louisville Kentucky	Dec 16 1924
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W Pratt ave

Instructions on back of certificate. See instructions on back of certificate.

FILM

Spec.—1-10-21—M&T—1500 Bks.

Edward White

92959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 92959

1-PLACE OF DEATH West Baltimore General Hospital

REGISTERED NO. 59

CITY OF BALTIMORE: (No. Payson ave + Dukeland ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward white.

(a) RESIDENCE NO. 1341 Division st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Jan 4 1895

7 AGE 29 Years 11 Months 8 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - odd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte NC.

PARENTS

10 NAME OF FATHER Jeff white

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlotte NC.

12 MAIDEN NAME OF MOTHER Nancy Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlotte NC.

14 Informant [illegible] (Address) [illegible]

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 12, 1924, that I last saw him alive on Dec 12, 1924, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia -

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Acute cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chmical

(Signed) Clement R. Monroe. M. D.

, 19 (Address) West Balto General Hospital Payson ave + Dukeland sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte N.C. DATE OF BURIAL Dec 15 1924

20 UNDERTAKER Samuel H Kinsley ADDRESS 715 N Bond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D

U.S.A.F. OD DARK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92960

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92960

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Andrew B. Sandell

(a) Residence No. 1225 Leighton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Wht	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 18, 1867.

7-AGE.	If LESS than 1 day,
57 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Inspector 1046

(b) General nature of industry, business, or establishment in which employed (or employer) Farmers.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Illinois.

PARENTS.

10-NAME OF FATHER, Mr. Edward C. Sandell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York.

12-MAIDEN NAME OF MOTHER, Mary Dwon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Iowa.

14- (Informant) Mrs. Sandell

(Address) 2500 St. Paul St.

15- Filed DEC 15 1924 19.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 19 24 to Dec 14 19 24

that I last saw him alive on Dec 14 19 24

and that death occurred, on the date stated above, at 8.55 p. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

Endocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem.

(Signed) A. Gaston Pearre, M. D.

. 19 (Address) Union Mem. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem	Dec 17 19 24
20-UNDERTAKER. Chas. E. Franck	ADDRESS 802 Madison Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 92961 E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D 92961

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1019 Ensor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie M. Lynch

(a) Residence No. 1019 Ensor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Francis J. Lynch

6-DATE OF BIRTH (month, day and year) Feb. 18. 1866

7-AGE. 58 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Balto Co Md

PARENTS:

10-NAME OF FATHER, Andrew Rowely

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Bailey

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), England

14- (Informant) Francis J. Lynch

(Address) 1019 Ensor St.

15- Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 13. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1924 to Dec. 13, 1924.

that I last saw her alive on Dec. 13 1924

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Arhythmia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. A. Hayden M. D.

12/15. 1924 (Address) 1216 N. Carrollton Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. Dec. 17, 1924

20-UNDERTAKER. Elmer W. Conklin ADDRESS 724 E. Eager St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92962

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 92962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 14 Bellwood ave St. Gardenview Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhemina L. Evans

(a) Residence No. 14 Bellwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Late W. H. Evans

6-DATE OF BIRTH (month, day and year) Jan. 15/1852

7-AGE 72 yrs. 9 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John Peters

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Karl Steiman

(Address) 1618 Belmont

15- Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12-24

I HEREBY CERTIFY, That I attended deceased from Dec. 4 1924 to Dec 12 1924

that I last saw h.. alive on Dec 12 1924

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Supposed

(Signed) J. C. Dunbarth M.D.

12-15 1924 (Address) 1531 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery. DATE OF BURIAL, Dec 15 1924

20-UNDERTAKER. George J. Ruth. ADDRESS 1735 Hoffman

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 92963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 92963

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 W. Preston ST., 17 WARD)

2-FULL NAME Grace E. Stevens

(a) RESIDENCE NO. 526 W. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. 7 da. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George W. Stevens

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work cook,
(b) General nature of industry, business, or establishment in which employed (or employer) Ost
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harry Stilley
(Address) 526 W. Preston St.

15 Filed DEC 15 1924, 192.. ROBERT P. KRAUTER, Registrar
Board of Health Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, inquiry find that said deceased came to her death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 da.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... da.

(Signed) J. J. Hennessy M. D.
(Coroner)

Dec. 15 192 4 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... da. In the State ..... yrs., ... mos., ... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec 15 1924

20 UNDERTAKER John H. Toadvine

ADDRESS 1827 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92964

CERTIFICATE OF DEATH.

101-001

D 92964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2235 W. Baltimore ST., 20 WARD)

2-FULL NAME John R. Hawkins

(a) RESIDENCE (Usual place of abode) No. 2235 W Baltimore ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22-1869

7 AGE — Years: 55 — Months — Days — If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: R. S. Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co. Md

12 MAIDEN NAME OF MOTHER: Susie Rider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A A Co Md

14 Informant: John J. McCullohon

(Address): 2235 W Baltimore St

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 13 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1924, to Dec 13, 1924, that I last saw him alive on Dec 13, 1924, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas L Cahn M. D.

12/5. 1924 (Address) 2105 N Bolto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 12 16 1924

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92965

CERTIFICATE OF DEATH.

D 92965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1136 W Hollins ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Van Egeren

(a) RESIDENCE No. 1136 Hollins St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Auguste Van Egeren

6 DATE OF BIRTH (month, day, and year): Mar 28. 1865

7 AGE: Years 59 Months 9 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Black Smith

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conelious Van Egeren

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Pickoneti Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Auguste Van Egeren

(Address) 1136 Hollins St

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 12. 1924.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1924. to Dec. 12. 1924.

that I last saw him alive on Dec. 12. 1924.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): None.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urine Analysis etc.

(Signed) Jas. S. Forton, M. D.

12/14/1924 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 12/15 1924

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollins sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92966

CERTIFICATE OF DEATH.

74-002

D 92966

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3000 Pinkney St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Morgan Rock

(a) RESIDENCE. No. 3000 Pinkney ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanora H Rock

6 DATE OF BIRTH (month, day, and year) Aug 23 91

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer Metropolitan

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jas Rock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Cynthia Nebl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Eleanora H. Rock
(Address) 3000 Pinkney St

15 Filed DEC 15 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1924, to Dec 12th, 1924, that I last saw him alive on Dec 12th, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 2 hrs.

CONTRIBUTORY (Secondary) Phlebitis. Ext Saphenous Vein

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W Garrison Harris M. D.

, 19 (Address) 4411 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Parkcemetery	Dec 15 1924
20 UNDERTAKER W. M. Routson	ADDRESS 2235 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92967

CERTIFICATE OF DEATH.

1884-003

1884 D 92967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospt ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Foster Williams

(a) RESIDENCE NO Spark Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Scholar
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Anna Cage Co
(State or country) Va

PARENTS

10 NAME OF FATHER Frank Williams

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF Hannah Williams

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Hezekiah Stewart
(Address) Sparks Md

15 Filed DEC 15 1924 192 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained at said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. 2 mos. 4 days

CONTRIBUTORY (Secondary) Struck by Auto

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Dec 15 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional Auto 778

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery Baltimore Co.	Dec 15 1924
20 UNDERTAKER H. C. Brooks.	ADDRESS Spark Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92968

CERTIFICATE OF DEATH.

31 D 92968

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Olszewska

(a) RESIDENCE NO. 520 S. Ann st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~Unknown~~ 35 yrs. mos. ds. How long in U. S., if of foreign birth? ~~Unknown~~ 35. yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Mike Blackovitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hospital Records

(Address) M.T.H.

15 Filed, DEC 15 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1924, to Dec. 13, 1924, that I last saw her alive on Dec. 13, 1924, and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Uncertain yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray & laboratory

(Signed) Nicholas J. Pekarz, M. D.

12-13-24, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Dec 16 1924
20 UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 92969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 92969

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Schneider

(a) RESIDENCE No. Levering House ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Finisher 814

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Municipal Hospital Records (Address)

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-10, 1924, to 12-11, 1924, that I last saw him alive on 12-11, 1924, and that death occurred, on the date stated above, at 5-00 p m.

The CAUSE OF DEATH* was as follows:

Acute Chronic Alcoholism

Cellulitis of Leg

Bronchopneumonia (Terminal)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub

(Signed) Claude G. Bruce M. D.

12-15-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL 12/15 1924

20 UNDERTAKER Thos N. J. Faith — ADDRESS 1737 W Pratt

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 3 ✓

D 92970

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Aisquith St ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel M. Jones

(a) RESIDENCE NO 1926 AIsquith St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 27/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		—	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Willis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances Siefert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Willis Jones
(Address) 1926 Aisquith St.

15 Filed DEC 15 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Walter, M. D. (Coroner.)

12/15/24 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 15 1924
20 UNDERTAKER Mrs R C Elliott	ADDRESS 1720 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92971

CERTIFICATE OF DEATH

90 D 92971

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Second Street ST.: Highlandtown 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addison Clayton

(a) RESIDENCE. No. 912 Second Street ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 84 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83 ~~84~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hannah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Joseph Clayton (Address) 912 S 2nd St Canton

15 Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 14, 1924, that I last saw h[illegible] alive on Dec 13, 1924 and that death occurred, on the date stated above, at 12:20 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decomp Arteriosclerosis

~~duration~~ yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Ds Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H Thomas, M. D.

Dec 14 1924 (Address) 702 S Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rosemary	Dec 17 1924

20 UNDERTAKER ADDRESS

Robert A Williams 1611 N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-24-5,B.R.S.-400 Bks.

D 92972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94-001 D 92972

1-PLACE OF DEATH

City of BALTIMORE: (No. Betty Dorsey St., 14 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1420 Bolton st

(a) Residence No. 1420 Bolton st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm R. Dorsey

6-DATE OF BIRTH (month, day and year) Feby 19-1830

7-AGE. 94 yrs. 9 mos. 25 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) New Market (State or Country), East Co Md

PARENTS.

10-NAME OF FATHER, Hiss C. Brashear

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Ann M. Potts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md Co

14- (Informant) Miss Lucy Dorsey

(Address) 1420 Bolton St

15-

Filed 192 ROBERT R. KRAUTER, Registrar.

DEC 15 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 15th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20 1924 to Dec 15 1924

that I last saw h. alive on Dec 14 1924

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there no autopsy?

What test confirmed diagnosis?

(Signed) E. C. Quinn, M. D.

, 19 (Address) 1733 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem Co Md

DATE OF BURIAL. Dec. 17 1924

20-UNDERTAKER. Harry W. Ehlen

ADDRESS 1944 W North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Karis

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92973 — REGISTERED NO. D 92973

188-00 145 lbs Muscular

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mid Hosp - Baste - 4 St. - 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Karis

(a) RESIDENCE NO. Wheeling West Virginia WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred non Resident mos. 3 ds. How long in U. S., if of foreign birth? 3 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Lithuania

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trackman

(b) General nature of industry, business, or establishment in which employed (or employer) R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant ~~Not.~~ Joseph Glezela

(Address) 1928 W Caroline St

15 Filed DEC 15 1924 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17 I HEREBY CERTIFY, That I attended deceased from 11/29, 1921, to Dec 14, 1924.

that I last saw h~~im~~ alive on Dec 14, 1924

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Traumatic Paraplegia

(duration) 3 years 15 Days

CONTRIBUTORY (Secondary) Syphilis & Decubitis (duration) about 3 years mos. ds.

18 Where was disease contracted if not at place of death? Injured while at work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. S. Love Jr, M. D.

, 19 (Address) 1100 Druid Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 17 1924
20 UNDERTAKER	**ADDRESS**
John Garbiancikas	485 S. Pac. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.—400 Blks.

4125

D 92974 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9V D 92974
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 20 N. Streeper St. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry James

(a) Residence No. 20 N. Streeper St St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte James

6-DATE OF BIRTH (month, day and year) June 2, 1867

7-AGE. 57 yrs. 6 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Potter 086

(b) General nature of Industry, business, or establishment in which employed (or employer) E. Bennett

(c) Name of employer. Pottery Co.

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John James

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Rohme

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Charlotte James

(Address) 20 N. Streeper St.

15- DEC 15 1924

16- ROBERT P. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 3 1924 to Dec 12 1924

that I last saw him alive on Dec 12 1924

and that death occurred, on the date stated above, at 8 50 P. m.

The CAUSE OF DEATH* was as follows:

Embolism Coronary Artery

10 min

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration?) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) B. V. Kelly M. D.

, 19 (Address) 100 N Linwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. Dec 16, 1924

20-UNDERTAKER. H. Sander & Sons — ADDRESS 1710 Fleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 901 ✓ D 92975

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1734 Montpelier St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Amoe

(a) Residence No. 1734 Montpelier St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Sarah E.

6-DATE OF BIRTH (month, day and year) June 18, 1841

7-AGE. 83 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Isaac Amoe

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Amoe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Howard Amoe

(Address) 1922 E. 28th st

DEC 15 1924

Filed ..... 193 ..... JOSEPH P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 14, 1924

I HEREBY CERTIFY, That I attended deceased from Dec 17, 1924 to Dec 14, 1924

that I last saw him alive on Dec 14, 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D

19 (Address) 1714 N Leavenworth St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Dec 17, 1924

20-UNDERTAKER. Fickler & Fickler — ADDRESS 1739 Eager

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92976

D 92976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1121 Carroll St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Lyons

(a) Residence No. 1121 Carroll St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda M. Lyons

6-DATE OF BIRTH (month, day and year) Sept. 1 1875

7-AGE. 49 yrs. 3 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Special Officer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. dry Dock

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Lyons

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Sarah Wedemeyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14-(Informant) Matilda M. Lyons

(Address) 1121 Carroll St.

15-Filed DEC 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 1st 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1924 to Dec. 13 1924

that I last saw h. alive on Dec 12th 1924

and that death occurred, on the date stated above, at 5-30 P. M.

The CAUSE OF DEATH* was as follows:

Sarcoma (Spindle Cell) Breast Jaw (right)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastic to inguinal region Lungs - ?

(Duration) yrs. ? mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1922

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) Wade H. Frampton M. D

, 19 (Address) 1017 Poplar Grove

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL, Dec. 16 1924

20-UNDERTAKER Mr. & Mrs John H. Teufel & Son ADDRESS 801 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92977

CERTIFICATE OF DEATH.

D 92977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Shacklett

(a) RESIDENCE NO. Fallston Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-7-24

7 AGE: Years | Months | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Claude Shacklett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Catherine Shacklett

(Address) Eccleston, Md.

15 Filed DEC 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-7, 1924, to 12-10, 1924.

that I last saw her alive on 12-10, 1924,

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Depressed Fracture of Skull

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-10-24 To left fracture

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS DEC 15 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec-12-23-21-E.B.R.S.-400 Blks.

D 92978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92978

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 105 N. Carey St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry R. Kremer

(a) Residence No. 105 N. Carey St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed, or Divorced.~~ (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~: Grace L. Kremer

6-DATE OF BIRTH (month, day and year): Feb. 22, 1872

7-AGE: 52 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 050
(c) Name of employer: Himself

9-BIRTHPLACE (city or town) (State or Country): Balto, Md.

PARENTS:
10-NAME OF FATHER: Joseph R. Kremer
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto, Md
12-MAIDEN NAME OF MOTHER: Marion A. Clark
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto, Md.

14-(Informant): Grace L. Kremer
(Address): 105 N. Carey St.

15-Filed DEC 15 1924, 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 8 1924 to December 15 1924, that I last saw him alive on December 14 1924, and that death occurred, on the date stated above, at 5 A. m. The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation and Pulmonary Oedema

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Valvular Heart Disease

(Duration) yrs. Over 7 mos. ds.

18-Where was disease contracted if not at place of death? ~~v~~

Did an operation precede death? No Date of ~~v~~

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D.

Dec 15, 1924 (Address) 1203 W. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec. 17, 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E. Northern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92979

D 92979

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hosp. ST., 19 WARD)

2-FULL NAME M. Evelyn Haag

(a) RESIDENCE NO. 1417 W Franklin ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 - 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Carroll Haag
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Florence Parrott
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Carroll Haag
(Address) 1412 West Lexington

15 Filed 1924 Robert F. HARRISON, Burial Permit Clerk. Registrar

C 15

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th, 19 24, to Dec. 13th, 19 24, that I last saw her alive on Dec 13th, 19 24, and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Sub. Phrenic Abscess

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1417 W Franklin

Did an operation precede death? No Date of .....

Was there an autopsy? No X-ray

What test confirmed diagnosis? Clinical findings

(Signed) Wade E. Brengman, M. D.

, 19 (Address) 101 W Read Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Michaels Md — DATE OF BURIAL 12/17 1924

20 UNDERTAKER: William Cook — ADDRESS 507 E North Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21 – E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92980

D 92980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1415 Linden Avenue St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Theresa McElfresh

(a) Residence No. 1415 Linden Avenue St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Chas. W. McElfresh

6-DATE OF BIRTH (month, day and year) Nov. 8. 1867

7-AGE,	If LESS than 1 day,
57 yrs. 1 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS

10-NAME OF FATHER, Robert Applegarth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant) Dr. Chas. W. McElfresh
(Address) 1415 Linden Avenue

15-

Filed ..... 192.. Robert F. Harrison Registrar.

DEC 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 14-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1915 to Dec 14 1924

that I last saw h.. alive on Dec 14 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia coma

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hyperstenuric albuminuria

(Signed) Henry Adler, M. D

. 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	12/16 19 24

20-UNDERTAKER,	ADDRESS
Henry U. Myers and Son	805 N. Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 92981 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 92981

CERTIFICATE OF DEATH.

REGISTERED No. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 N. Luzerne ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Sargent

(Residence in Baltimore: No. 1328 N. Luzerne ave St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July 27, 1894 (Month) (Day) (Year)

7-AGE, 30 yrs. 4 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Wilmington Del.

PARENTS.

10-NAME OF FATHER, Wm A Sargent

11-BIRTHPLACE OF FATHER (State or Country), Maine

12-MAIDEN NAME OF MOTHER, Emma L Howard

13-BIRTHPLACE OF MOTHER (State or Country), Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Sargent

(Address) 1328 N. Luzerne ave

15- Filed DEC 15 1924, 191... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1916, to Dec 1924, that I saw h[er] alive on Dec 14 1924, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(Duration) 12 yrs. mos. ds.

(Signed) H L Roberts M. D.

..., 191... (Address) 728 W Northern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Presbyterian — DATE OF BURIAL, Dec 16, 1924

20-UNDERTAKER Henry Lutz — ADDRESS 1203 W. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 129

City of BALTIMORE: (No. 408 S Exeter St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Yager

(a) Residence No. 108 S Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Yager

6-DATE OF BIRTH (month, day and year) ? 1842

7-AGE. 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home work

(b) General nature of industry, business, or establishment in which employed (or employer). None

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14-

(Informant) Mary Yager

(Address) 408 S Exeter

15-

Filed DEC 15 1924, 19

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). December 13 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 19 24 to Dec 13 19 24

that I last saw her alive on Dec 13 19 24

and that death occurred, on the date stated above, at 12.0 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bright's Disease

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M D

Dec 14, 192 (Address) 14 So Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Vincents — DATE OF BURIAL, December, 192

20-UNDERTAKER, Wendell Oppel & Son — ADDRESS 37 S Amm

WHITE PENCIL WRITING SHOULD be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

405 Albemarle St.

D 92983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. St. Josephs Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dan Greene

(a) Residence No. 405 Albemarle St., City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) October 1857

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS

10-NAME OF FATHER, John Greene

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Bess Finn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14-(Informant) Daniel

(Address) 102 S. Chapel

15-Filed DEC 15 1924 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 14 24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1924 to Dec. 14, 1924 that I last saw him alive on Dec 14, 7 PM 1924 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia and Toxemia — Intestinal obstruction due to Strangulated Hernia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

36 hours (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 12/13/24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical and Operative

(Signed) D. E. Thornburg M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: Dec 18, 1924

20-UNDERTAKER: Wendell Offutt ADDRESS: 37 Dan

Instructions: Fill in all items EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92984

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92984

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1763 N. Gay St. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hess

(a) RESIDENCE NO. 1763 N. Gay St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15, 1903 Guess

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) B. F. D.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. H. Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rose Saulsbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. H. Hess
(Address) 1763 N. Gay St.

15 Filed DEC 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of neck.
Falling Chimney
accidental (Duration) ..... yrs. ..... mos ..... ds.
CONTRIBUTORY (House afire)
(Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)
Dec. 15, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Dec 17 1924

20 UNDERTAKER Dorsey & Ruth — ADDRESS 1735 Eastern ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 92985

D 92985

CERTIFICATE OF DEATH.

REGISTERED NO. 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 4 WARD)

2-FULL NAME Jos. Paulauskas

(a) RESIDENCE NO. 36 E Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Paulauskas

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Mrs. Paulauskas
(Address) 36 E Pratt St.

15 Filed DEC 15 1924 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 192 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

(Signed) H. Grason Kelly, M. D.
(Coroner.)
192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent — DATE OF BURIAL Dec. 17 1924

20 UNDERTAKER Elias D Buchauskas — ADDRESS 637 Park Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92986

CERTIFICATE OF DEATH.

161-001

D 92986

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St. Joseph Hospital ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Boy Hanna

(a) Residence No. 3 Gardenwood Rd Baby Hamiltonwood

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 15, 1924

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or — min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). St. Joseph Hospital Baltimore Md.

PARENTS

10-NAME OF FATHER, Thomas Ignas

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa.

12-MAIDEN NAME OF MOTHER, Mary Bochum

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa.

14- (Informant) Thomas Ignas

(Address) 3 Gardenwood Rd

15- Filed ..... 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1924 9 A.M. to Dec. 15, 1924 11:30 A.M.

that I last saw him alive on Dec. 15, 1924 11:30 A.M.

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxiation

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings,

(Signed) B.M.K. Hodes, M. D.

, 19 (Address) St. Joseph Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Vincents Cem. DATE OF BURIAL. Dec. 16, 1924

20-UNDERTAKER. Leonard J. Rusch ADDRESS Hamilton Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92987

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 92987

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2130 Madison Ave WARD 14)

2-FULL NAME Beulah May Guest

(a) RESIDENCE No 2130 Madison Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 2 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John M. Mooney

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Helen Guest

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.Y.

14 Informant Helen Guest
(Address) 2130 Madison Ave.

15 Filed DEC 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) no contrib

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 15, 1924 (Address) 2802 Eldendon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Dec 16 1924
20 UNDERTAKER W. J. McKenrey Sons	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Spec.–1-10-21—M&T—1500 Bks.

Lucca

D 92988 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X12 D 92988

1-PLACE OF DEATH U.S. Marine Hospital No 1. Baltimore, Md

REGISTERED NO.....

CITY OF BALTIMORE: (No.....ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Lucca

U.S Marine Hospital No 1 Baltimore Md

(a) RESIDENCE NO. Ponce, Porto Rico ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steaman, (wiper)

(b) General nature of industry, business, or establishment in which employed (or employer) wiper 086

(c) Name of employer S/S Beatrice

9 BIRTHPLACE (city or town) (State or country) Ponce Porto Rico.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Viola Pacheco

13 BIRTHPLACE OF MOTHER (city or town) Porto Rico (State or country)

14 Informant Self

(Address)

15 Filed . 19 ROBERT B. KRAUER, Registrar

DEC 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1924. to Dec. 15, 1924.

that I last saw him alive on Dec 15, 1924.

and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Septicemia.

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Abrasion of Liver.

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Oct 30, 1924

Was there an autopsy? No

What test confirmed diagnosis? Physical test and Laboratory M. A. Fisher

(Signed) M. D.

Dec 16, 19 (Address) U.S Marine Hospital No 1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetry — DATE OF BURIAL Dec 15, 24

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92989

HEALTH DEPARTMENT—CITY OF BALTIMORE

1924 D 92989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1211 W. North Ave St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Herzfeld

(a) Residence No. 1211 W. North Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or ~~divorced~~, HUSBAND of (or) WIFE of Pink Herman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 71 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Russia

PARENTS.

10-NAME OF FATHER, Benj Levinson

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Russia

12-MAIDEN NAME OF MOTHER, Yetta Herzfeld

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Russia

14- (Informant) Joseph Herzfeld

(Address) 1211 W. North Ave

15-

Filed..... 192.....

ROBERT R. KRAUTER, Registrar.

DEC 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 15/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923 to Dec 14, 1924

that I last saw h.. alive on Dec 14, 1924

and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo & Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis acute cardiac dilation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jos E Kelly M. D.

(Address) 516 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL, 12/15 1924

20-UNDERTAKER Sol Levinson & Bro

ADDRESS 124 E Balto St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92990 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 92990
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1226 N. Caroline St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Goverman

(a) Residence No. 1226 N. Caroline St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Abe Goverman

6-DATE OF BIRTH (month, day and year) Sept 21 1898

7-AGE. 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Abe Goverman
(Address) 1226 N. Caroline st

15- Filed DEC 16 1924 ROBERT R. [illegible] Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/15/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924 to Dec 15, 1924 that I last saw h. alive on Dec 15, 1924 and that death occurred, on the date stated above, at 3 30 a. m. The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Decubitus Foot

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Typical

(Signed) M. Thomas, M. D.

(Address) 122 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Herring Run — DATE OF BURIAL, 12/15, 1924

20-UNDERTAKER, Joh Linton & Bro — ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92991

CERTIFICATE OF DEATH.

D 92991

Registered No. 100-B 92991

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Casey

(a) Residence No. Co Keysville Md St., Ward

(Usual place of abode) (If non residents give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Michael Collins

6-DATE OF BIRTH (month, day and year) Nov. 1859

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. John Brannan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Dougherty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Catherine Dougherty

(Address) Cockeysville

15- Filed DEC 16 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 19 24 to Dec. 14 19 24

that I last saw her alive on Dec 14 19 24

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Myocarditis.

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Infected ulcer of Both Legs

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hyp. & Clin. Data

(Signed) Geo. B. Gilbert M. D

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Texas. Md

DATE OF BURIAL. Dec 17 19 24

20-UNDERTAKER. W C Brooks

ADDRESS Texas Md

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92992

CERTIFICATE OF DEATH.

D 92992

REGISTERED No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 176 Heber ST. 94 WARD)

2-FULL NAME Conrad Kern

(a) RESIDENCE NO. 176 Heber ST., 94 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~Wife of~~ Eliz. Kern

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Kern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hickmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Kern

(Address) 176 Heber St

15 Filed DEC 16 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 19 24

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Dec 12 1924.

that I last saw him alive on Dec 12, 1924

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Arteriosclerosis (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Graham, M. D.

Dec 15 1924, 19 (Address) 3100 Hampden Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenslager & Co	12/16 19 24
20 UNDERTAKER	ADDRESS
John F. Lahey & Sons	131 S Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92993

CERTIFICATE OF DEATH.

57 D 92993

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 Singer Avenue ST. 13 WARD)

2-FULL NAME Anna Knell

(a) RESIDENCE. No. 227 Singer Avenue ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Frank Knell

6 DATE OF BIRTH (month, day, and year) Oct 8th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Windischenbach Germany

PARENTS

10 NAME OF FATHER George Regar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Windischenbach Germany

12 MAIDEN NAME OF MOTHER Mrs Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Windischenbach Germany

14 Informant (Address) Casimir Gilla 1094 N Eden Ave

15 Filed DEC 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1927, to Dec 14th, 1927, that I last saw her alive on Dec 14th, 1927, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? — no —

What test confirmed diagnosis? Clinical & Urinalysis.

(Signed) Wm F Kreiser, M. D.

12/15 1927 (Address) 1701 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethesda Cemetary	Dec 17th 1927

20 UNDERTAKER Knull & Son ADDRESS 1721 W Pratt St

Spec.—1-10-21—M&T—1500 Bks.

D 92994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92994

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen. Hosp ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Tennant.

(a) RESIDENCE No. 740 Light St ST., ...WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2 days.	0	0	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Tennant

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Constance Salonia

13 BIRTHPLACE OF MOTHER (city or town) Chicago
(State or country) Ill.

14 Informant Mrs. Wm Tennant
(Address) 740 Light St.

15 Filed DEC 16 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1924. to Dec 15, 1924.
that I last saw h[illegible]alive on Dec 15, 1924
and that death occurred, on the date stated above, at 5 20 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Forceps Delivery
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Signs & Symptoms
(Signed) J. R. Petterman, M. D.
, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co.	Dec 16 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S.A.F.
OD DAK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 92995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 92995
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Leadenhall St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Burley

(a) Residence No. 921 Leadenhall St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: C

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Aug 25, 1849

7-AGE: 25 yrs. 3 mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer 40
(b) General nature of industry, business, or establishment in which employed (or employer): Ammunition Co
(c) Name of employer: "

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Elijah Burley

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Simms

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-
(Informant): Bennetta Green
(Address): 916 Leadenhall

DEC 16 1924 192 ROBERT R. [illegible] Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/14/24

17- I HEREBY CERTIFY, That I attended deceased from 12/3, 1924 to 12/14, 1924
that I last saw him alive on 12/13, 1924
and that death occurred, on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. McCard M. D.

12/15, 1924 (Address) 1005 Hollins

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Olivet	Dec 17 1924
20-UNDERTAKER.	ADDRESS
A. P. Brown and Son	108 W Monta

THIS IS A PERMANENT RECORD. Every item of information must be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92996

CERTIFICATE OF DEATH.

78 D 92996

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 E. Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellwood Hosman

(a) RESIDENCE No. 2231 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27/80

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Piano Player
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Thos. J. Hosman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs M Wermuth
(Address) 2236 E Fayette St

15 Filed DEC 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
(Probably)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy
(duration) 10 yrs. mos. ds.

(Signed) J. S. Bolen, M. D.
(Coroner.)

12/15/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk — DATE OF BURIAL 12/16 1924

20 UNDERTAKER Philip Herwig — ADDRESS 1016 Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92997

CERTIFICATE OF DEATH.

90 D 92997

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2340 McElderry ST., 6 WARD)

2-FULL NAME Charles Dennis

(a) RESIDENCE NO 27 N Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 18/1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oystar Shucker

(b) General nature of industry, business, or establishment in which employed (or employer) & brick-maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Harriett Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co.

14 Informant Hester Durkin (sister)

(Address) 1505 Jefferson St.

15 DEC 16 1924 192 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency possibly valvular. (Dropped dead while shucking oysters.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Patterson, M. D. (Coroner.)

12/19/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Md

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 12/17/24 192

20 UNDERTAKER Theodore G. Hirsh

ADDRESS 113 S Wolfe St

Spec.—1-10-21—M&T—1500 Blks.

D 92998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 92998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Etting ST., 14 WARD)

2-FULL NAME Ada Elizabeth Jenkins

(a) RESIDENCE NO. 2215 Etting ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 90

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C

PARENTS

10 NAME OF FATHER Fred Jenkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washgtn D.C.

12 MAIDEN NAME OF MOTHER Malinda Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Charles Reed (Address) 567 Baker St.

15 Filed DEC 16 1924 19 ROBERT R. KRAUTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 15, 1923, to Dec 13, 1924, that I last saw her alive on Dec 13, 1924, and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

12/15, 19 24 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 16 1924
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N. Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 92999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 92999

CERTIFICATE OF DEATH.

24 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angie G. Rollins.

(a) RESIDENCE NO. 1815 Jackson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 16, 1908.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	0	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Portland, Me.
(State or country)

PARENTS

10 NAME OF FATHER John Rollins.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Parkerhead, Me.

12 MAIDEN NAME OF MOTHER Alice J. Grant.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bangor, Me.

14 Informant John Rollins. (father)
(Address) 1815 Jackson St.

15 Filed ---- 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the face and body from a gas range.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Dec. 15, 1924 (Address) 1011 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
Accident at 1815 Jackson st. Dec. 14/24

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery DATE OF BURIAL Dec 17 1924

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT–CITY OF BALTIMORE

D 93000

1 PLACE OF DEATH

CERTIFICATE OF DEATH

74-002

D 93000

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 207 Arch St. ST. ..... WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thergood Watson.

(Residence in Baltimore: No. 207 Arch St. St.: 12 yrs. 3 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 4 (Day), 1872 (Year)

7 AGE: 52 yrs. 5 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: General Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: ——— Watson.

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dan'l Eaton

(Address) Undertaker

15. ROBERT R. KRAUTER, Burial Permit Clerk.

Filed DEC 16 1924 191.. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 12 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924, to Dec 12 1924, that I saw him alive on December 12, 1924, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia,
possibly from embolus.
(Duration) 0 yrs. 1 mos. 0. ds

Contributory (SECONDARY) General Exhaustion:
unable to take nourishment
(Duration) 0 yrs. 0 mos. 10 ds.

(Signed) John Estandberry M. D.

Dec 13, 1924 (Address) 1037 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 12-16-191..

20 UNDERTAKER: Dan'l Eaton — ADDRESS: 916 Ba ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93001

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 306 N. Appleton St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Albright

(a) Residence No. 306 N. Appleton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of 7/6/24

6-DATE OF BIRTH (month, day and year) 7/6/24

7-AGE. ..... yrs. 5 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore

(State or Country) Md

PARENTS.

10-NAME OF FATHER, John Albright

11-BIRTHPLACE OF FATHER (city or town) Baltimore

(State or Country) Md

12-MAIDEN NAME OF MOTHER, Nancy Stewart

13-BIRTHPLACE OF MOTHER (city or town) Maryland

(State or Country) Md

14- (Informant) John Albright

(Address) 306 N. Appleton St

15- Filed DEC 16 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/15/24

17- I HEREBY CERTIFY, That I attended deceased from 12/13 1924 to 12/15 1924

that I last saw h.. alive on 12/14 1924

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/15 1924 (Address) 8080 Pulaski Hwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. 12-16-24

20-UNDERTAKER Dowell Carton

ADDRESS 916 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93002

CERTIFICATE OF DEATH.

32 D 93002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 18 WARD)

2-FULL NAME Julia Dix

(a) RESIDENCE NO. 1044 W. Lexington St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Dix

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Virginia

PARENTS

10 NAME OF FATHER! Williams

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Unknown

14 Informant ... (Address) Johns Hopkins Hospital.

15 Filed DEC 16 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1924, to Dec. 14, 1924, that I last saw her alive on Dec. 14, 1924, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis 7 days.

(duration) yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 7 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? — yes

What test confirmed diagnosis? —

(Signed) E. L. Stone M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tafters Wharf Va — DATE OF BURIAL 12-16-24

20 UNDERTAKER David Easton — ADDRESS 916 Pe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93003

CERTIFICATE OF DEATH

100-D 93003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., V WARD)

2-FULL NAME Harry Sugar

(a) RESIDENCE NO. 2026 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Sugar

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Sugar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1409 E Baltimore St

15 DEC 16 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from December 12, 1924, to December 16, 1924, that I last saw him alive on Dec. 16, 1924 and that death occurred, on the date stated above, at 12.15 a m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis Clinically & lab.

(Signed) I. Spiegel L. Jay M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew [illegible]	12/16 1924

20 UNDERTAKER Jack Lewis ADDRESS 1409 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93004

D 93004

CERTIFICATE OF DEATH.

REGISTERED NO. 8V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hosp ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Abramovitz

(a) RESIDENCE NO. 1705 E Baltimore St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Dr. Morris Abramovitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pauline Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Father
(Address)

15 Filed DEC 16 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924, to Dec 16, 1924, that I last saw h alive on Dec 14 1924, and that death occurred, on the date stated above, at 5 20 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Zell, M. D.

12/16 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holmes Wash. Road — DATE OF BURIAL 12-16 1924

20 UNDERTAKER Jas T Lewis, 4397 Belta — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Law pl ST. 14 WARD)

2-FULL NAME Thomas J. Shaughnessy

(a) RESIDENCE NO. 1636 Law pl ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Sinia C. Burch

6 DATE OF BIRTH (month, day, and year) — — 1869

7 AGE Years 55 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal 045

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Augusta Ga.

PARENTS

10 NAME OF FATHER Richard Shaughnessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sinia C. Shaughnessy (Address) 1636 Law pl

15 Filed . 19 ROBERT R. KRAUTER, Registrar

DEC 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1924

17 I HEREBY CERTIFY, That I attended deceased from September 1924 to Dec 13 1924, that I last saw him alive on Dec 13 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Heart Disease & Arterial Sclerosis

None (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank E. Moyer, M. D.

, 19 (Address) 1501 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 12/17/19 24

20 UNDERTAKER J. F. Fahey & Sons ADDRESS 5 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93006

CERTIFICATE OF DEATH.

88

D 93006

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1214 N Calvert St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Hanson Robertson

(a) Residence No. 1214 N Calvert St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. 4 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Estelle F. Robertson

6-DATE OF BIRTH (month, day and year) July-27-1849

7-AGE, 75 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Law

(c) Name of employer Self

9-BIRTHPLACE (city or town) (State or Country), Charles Co. Maryland

PARENTS.

10-NAME OF FATHER Alex. P. H. Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Charles Co. Maryland

12-MAIDEN NAME OF MOTHER, Verlinda Forke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Tangier Co. Virginia

14- (Informant) Mrs. W. P. Hill (daughter)

(Address) Edgewood Apts

15-

DEC 16 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/14/24

17- I HEREBY CERTIFY, That I attended deceased from 11/22 1924 to 12/14 1924

that I last saw h.. alive on 12/14 1924

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Prostatitis

(Duration) ... yrs. ... mos. 22 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Bierbaugh M. D.

12/15 1924 (Address) 1408 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery

DATE OF BURIAL, Dec 16 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO should be carefully supplied. AGE should be stated E In plain terms, so that it may be properly classified. Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward) 73

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... William Perzolt

(a) Residence No.... Preston Valley Rd. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

~~Unmarried~~ widowed, or ~~divorced~~ HUSBAND of (or) ~~Wife of~~ Sadie Parker.

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, about 70 yrs. If LESS than 1 day, ...yrs.....mos.....ds. ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... nil

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Adam Perzolt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), —

12-MAIDEN NAME OF MOTHER, Elizabeth ××

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant)... Sister Superior

(Address)... Preston Valley

15- DEC 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 15/24

17- I HEREBY CERTIFY, That I attended deceased from No record, 19....., to....., 19.....,

that I last saw h... alive on Dec. 14, 19 24

and that death occurred, on the date stated above, at 10. a. m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

Unknown (Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration)...yrs...mos...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

Clerk (Signed) F. A. Mann, M. D.

N, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral | DATE OF BURIAL, Dec 16, 1924

20-UNDERTAKER, H. C. Wiedefeld | ADDRESS 914 Fremont Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93008

CERTIFICATE OF DEATH.

14 74001 D 93008

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Ethiny St. ST., 14 WARD)

2-FULL NAME Nicholas Thornton

(a) RESIDENCE NO. 1616 Ethiny St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) about 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None (blind)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant May Pratt
(Address) 524 N. Fremont Ave

15 Filed DEC 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
about 1 hr
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hennessy, M. D.
(Coroner.)
Dec. 14, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lion Cemty	12/17/24
20 UNDERTAKER	ADDRESS
Mrs Eden A. Hollan	1631 Bond

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93009

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 93009

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 Fleet St., V Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Hollé

(a) Residence No. 1725 Fleet St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6-DATE OF BIRTH (month, day and year) Dec 15 1924.

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 8 hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, George Hollé

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Antoinette Bozzuto

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) George Hollé

(Address) 1725 Fleet St.

Filed DEC 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1924 to Dec 16 1924

that I last saw him alive on Dec. 16 1924

and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pneumonia

(Following Childbirth)

(Duration) yrs. 1 mos. 8 hours ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/16, 1924 (Address) 1726 Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Dec 19, 1924
Interment	
20-UNDERTAKER. Wendell Dyer & Son	ADDRESS 378 Ins

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93010

CERTIFICATE OF DEATH.

100 D 93010

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1112 S. Lakewood Ave. ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Norwich (Norwas)

(a) RESIDENCE No. 1112 S. Lakewood Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Norwich (Norwas)

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sewing Machine
(b) General nature of industry, business, or establishment in which employed (or employer) Repairing —
(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Norwich. (Norwas)
(Address) 519 S. Caton St.

15 Filed ....., 192 Robert P. Harrison, Registrar

DEC 16 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Dec death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bones - Tuberculosis.

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) 4 yrs. 1 mos. ..... ds.

(Signed) Geo. Lewis Wades, M. D.
(Coroner)

12/14/24, 192 (Address) 1756 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Dec 17. 1924.

20 UNDERTAKER M. J. Sadowski. ADDRESS 705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93011

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 25 W. Spring ave St. 27 Ward) Ralpberg

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Miller

(a) Residence No. 25 W. Spring ave St. ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Miller

6-DATE OF BIRTH (month, day and year) Nov. 27th 1847

7-AGE. 77 yrs. mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Franz Koch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Reinhardt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) William Miller

(Address) 25 W. Spring ave Ralpberg

15- Filed ..... 1924 Robert J. Bitter Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 14th 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1924 to Dec 13 1924

that I last saw her alive on Dec 13 1924

and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Vascular Heart disease.

Paralysis of Heart muscle.

Duration ..... yrs. ..... mos. ..... ds.

Edema of Lungs

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? -

(Signed) Albert L. Webster M. D

19 (Address) 703 Belair Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	Dec. 17th 1924

20-UNDERTAKER. Lilly & Zeile ADDRESS 403 S. Wolfe St

DEC 16 1924

Burial Permit Clerk.

IN. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

NK—THIS IS A PERMANENT RECORD. Every item of infor-
GE should be stated EXACTLY. PHYSICIANS should make
at it may be properly classified. Exact statement of OCCUPA-
s on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

D 93012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93012

188-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Hommens Hospital ST. 14 WARD)

2-FULL NAME Fantelina S. Thomas

(a) RESIDENCE No. 1605 Bolton St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James N. Thomas

6 DATE OF BIRTH (month, day, and year) Oct 9. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER Jos F. Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Rebecca Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Armstrong Thomas
(Address) 1605 Bolton St

15 Filed DEC 16 1924 192 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of right humerus (accidental)! struck by street car. (duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 7 ds.

(Signed) J. F. Hennessy, M. D.
(Coroner.)
Dec. 15, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL All Faiths Church, St Marys Co Md. DATE OF BURIAL Dec 17 1924

20 UNDERTAKER John Mitchell ADDRESS 1201 N. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 D 93013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93013

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Orrin

(a) RESIDENCE NO. 7 Paris St City of Mexico WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Myrtle Orrin

6 DATE OF BIRTH (month, day, and year): Oct 7 1894

7 AGE: Years 29 Months 2 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Troy N.Y.

PARENTS

10 NAME OF FATHER: Edward W. Orrin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cinn. Ohio

12 MAIDEN NAME OF MOTHER: Lillah Covert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant (Address): Records Johns Hopkins Hosp

15 Filed . 19 Registrar

DEC 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 14 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 - , 1924, to Dec 14 - , 1924, that I last saw him alive on Dec 14 - , 1924, and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Acute cardiac dilatation -

Cardiac disease (duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical picture.

(Signed) Chas. H. Cameron M. D.

12/14/24 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mexico City. Mexico

DATE OF BURIAL: Dec 20 1924

20 UNDERTAKER: John Mitchell

ADDRESS: 1201 W. Fayette

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 277 S. Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry John Funk, Jr.

(a) Residence No. 274 S. Robinson St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Funk

6-DATE OF BIRTH (month, day and year) May 18-1900

7-AGE. 24 yrs. 6 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer): 084

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Henry J. Funk

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md.

12-MAIDEN NAME OF MOTHER: Carrie Hirschman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto., Md

14- (Informant): Carrie Funk

(Address): 277 S. Robinson St.

15- Filed Dec 16 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 (when born) 1924 to Dec 14 1924 that I last saw him alive on Dec 14 1924 and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Immediate Cause

(Signed) W. D. Mohler, M. D.

. 19 (Address) 301 S Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. DATE OF BURIAL: Dec. 17, 1924

20-UNDERTAKER: Zirkler & Zirkler ADDRESS: 1739 E. Eager St.

DEC 16 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93015

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1628 Jackson St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie V. Weber

(a) Residence No. 1628 Jackson St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm. G.

6-DATE OF BIRTH (month, day and year) July 14, 1870

7-AGE. 54 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Wm H. Hutson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Mary Scheff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Wm G. Weber

(Address) 1628 Jackson

15-

Filed DEC 16 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 15, 1924

I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924, to Dec 15, 1924

that I last saw h.. alive on Dec 15, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Typical signs

(Signed) Sidney L. Tuteth M. D

12/16, 1924 (Address) 446 E Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore — DATE OF BURIAL. Dec 16, 1924

20-UNDERTAKER. Gurkin & Gurkin — ADDRESS 1739 Eager

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93016

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1117 Brentwood Ave. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Dougherty

(a) Residence No. 1117 Brentwood Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House-work

(b) General nature of Industry, business, or establishment in which employed (or employer). at home

(c) Name of employer.

9-BIRTHPLACE (city or town).....
(State or Country). Kentucky

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Not Known

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Not Known

14- (Informant). Mrs. McKenna
(Address). 1117 Brentwood Ave.

15- Filed 192 Robert P. Harrison, Registrar.

DEC 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1924 to Dec 14 1924

that I last saw him alive on Dec 14 1924

and that death occurred, on the date stated above, at 12 5-8 m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton M. D.

12 6 1924 (Address) 4006 Chester

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	Dec. 17 1924
20-UNDERTAKER.	ADDRESS
E. I. Fanning & Son-1938	E. Lafayette

(1) B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is especially important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] may be important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93017

CERTIFICATE OF DEATH.

D 93017

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 728 Cumberland St. 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Blackiston

(a) RESIDENCE NO. 728 Cumberland St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guard

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Blackiston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma E Bowden

(Address) 728 E Cumberland

15 Dec 16 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

DEC 16 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1924, to Dec 15, 1924, that I last saw him alive on Dec 14th, 1924, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Infirmity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D Bryant, M. D.

, 19 (Address) 611 N Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 18 1924

20 UNDERTAKER: Wm Cole — ADDRESS: 500 E Fayette

D 93018 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93018

CERTIFICATE OF DEATH. 90

Registered No. 9

1-PLACE OF DEATH

City of BALTIMORE: (No. 3507 Old York Rd St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D Bremer

(a) Residence No. 3507 Old York Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): June 16 1917

7-AGE: 7 yrs. 6 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Otto Bremer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary G Long

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant): Otto Bremer

(Address): 3507 Old York Rd.

15- Roberts Funeral Home

Dec 17 192 Burial Permit Issued Registrar.

DEC 16 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1924 to Dec 15 1924

that I last saw her alive on Dec 14 1924

and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pleural Effusion

(Duration) 7½ yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Hungerford M.D.

19 12/15/24 (Address) 701 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: Dec 17. 1924

20-UNDERTAKER: Wm Cook — ADDRESS 502 E North Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

D 93019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93019

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Mangold ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bruchey.

(a) RESIDENCE No. 809 Mangold ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo E. Bruchey.

6 DATE OF BIRTH (month, day, and year) Mar 12 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	9.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Smithson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mary E. Shilan.

(Address) 804 Mangold

15 Filed DEC 16 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16/1924

17

I HEREBY CERTIFY, That I attended deceased from 12/13/24, 19..., to 12/16, 1924.

that I last saw h alive on 12/16, 1924

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Duration

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Thos. Brand M. D.

, 19 (Address) 1227 Madison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 19 1924

20 UNDERTAKER Thos Cook & Son

ADDRESS 526 North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY

Spec.—1-10-21—M&T—1500 Blks.

D 93020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93020

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1828 N. Bethel ST., 8 WARD)

2-FULL NAME Charles G. Arnett

(a) RESIDENCE NO. 1828 N. Bethel ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Arnett

6 DATE OF BIRTH (month, day, and year) 11-26-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Finisher

(b) General nature of Industry, business, or establishment in which employed (or employer) Mr. Shaw Co

(c) Name of employer 010

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Levi Arnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mc Laughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Emma A. Arnett 1828 N. Bethel

15 Filed DEC 16 1924, 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15- 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Dec 15, 1924

that I last saw him alive on Dec. 12, 1924

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Arthritis.

(duration) 1 yrs. 5 mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

12/15, 1924 (Signed) J. A. Bowden, M. D.

(Address) 1516 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ballanon Cemetery DATE OF BURIAL 12/18 1924

20 UNDERTAKER William Cook ADDRESS 502 E. Vall

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1120 Etting St., 17 Ward) Registered No. 101-08

2-FULL NAME Monie Thuston

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1120 Etting St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, ~~Married~~ Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Va (State or Country),

PARENTS.

10-NAME OF FATHER, Daniel Thuston

11-BIRTHPLACE OF FATHER (city or town) Va (State or Country),

12-MAIDEN NAME OF MOTHER, not Known

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country),

14- (Informant) Cora Thuston

(Address) 1120 Etting St.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

~~DEC 6 1924~~ ~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 15 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1924 to Dec 15 1924

that I last saw him alive on Dec 15 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Frank E. Wagner M. D.

12/16/ 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mill Creek Wharf Va. DATE OF BURIAL, DEC 16 1924

20-UNDERTAKER, Walter B. Spriggs ADDRESS 114 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS FORM MUST BE FILLED OUT IN FULL. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

(Moore.)

D 93022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93022

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 W. Hill ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Moore

(a) RESIDENCE NO. 112 W. Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) about Unknown 1870

7 AGE 54 Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O & O

(c) Name of employer B. C. & A. Steam boat Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Moore.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Fannie Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Rachel Grayson

(Address) 112 W. Hill Street.

15 Filed DEC 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 14, 1924.

that I last saw h— alive on Dec 14, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastritis Chronic

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles F. Fisher M. D.

Dec 15 (Address) 712 S. Ann St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	12/17 1924
20 UNDERTAKER Walter D. Spriggs	ADDRESS 144 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93023

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 Furrow St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles A. G. Paul

(a) Residence No. 312 Furrow St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 7 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Paul

6-DATE OF BIRTH (month, day and year) April 29 1883

7-AGE. 41 yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore

(State or Country), Md

PARENTS.

10-NAME OF FATHER, Arthur Paul

11-BIRTHPLACE OF FATHER (city or town) Baltimore

(State or Country), Md

12-MAIDEN NAME OF MOTHER, Ellen Brereton

13-BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or Country), Md

14- (Informant) Annie M. Paul

(Address) 312 Furrow St

15- Filed DEC 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 16-24

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1924 to Dec 16, 1924, that I last saw him alive on Dec 15, 1924, and that death occurred, on the date stated above, at 6-40 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal Tuberculosis

(Duration) over 7 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No By whom Lab Tests

What test confirmed diagnosis? Sputum & Throat

(Signed) M.D.

Dec 16, 1924 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet — DATE OF BURIAL. Dec 15, 1924

20-UNDERTAKER. George J Smith — ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS FORM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Bks.

D 93024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93024

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Arden Road, Mt. Washington St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Brink

(a) Residence No. Arden Road, Mt. Washington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William A. Brink

6-DATE OF BIRTH (month, day and year) Jan. 21, 1862

7-AGE. 62 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Jeremiah Ryan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Jordan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Mrs. H.T. Worthington

(Address) Arden Road

15- Filed DEC 16 1924 19.. Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 23 1924 to Dec 15 19.24

that I last saw her alive on Dec 14 19.24

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Alan C. Sutton M. D

Dec 15. 1924 (Address) 1107 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 12/17, 19.24

20-UNDERTAKER. Henry W. Myers and Son

ADDRESS 805 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93025

CERTIFICATE OF DEATH.

X 74 B 01

B 93025

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Custom House, Lombard & Gay Sts. ST., 4 WARD)

2-FULL NAME James Franklin Leib.

(a) RESIDENCE NO. Pa.& Washington Aves. Towson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos.--- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXXXX XXXXXXXX Mary V.Leib.

6 DATE OF BIRTH (month, day, and year) December 20,1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chief of Marine Dept.
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.Custom House.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.Md.

PARENTS

10 NAME OF FATHER William H.Leib.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stewardstown,Pa.

12 MAIDEN NAME OF MOTHER Eliza Allen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Park,Pa.

14 Informant Mary V.Leib.(wife)
(Address) Pa.& Washington Aves Towson.

15 Filed DEC 16 1924 19.. Burial Permit Clerk
Registrar

NB.—WRITE PLAINLY, with ink. All questions must be answered. AGE should be stated EXACTLY. If unknown, approximate it. PHYSICIAN'S mation should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 15,1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Dec. 15, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cemetery

DATE OF BURIAL 12/17 192 24

20 UNDERTAKER Henry W. Mears and Son ADDRESS 705 E. Calvert St.

Spec.—1-10-21—M&T—1500 Blks.

D 93026

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93026

CERTIFICATE OF DEATH.

100-80

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that information should be stated EXACTLY. PHYSICIANS should be careful to see that information should be stated EXACTLY. AGE

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 93027

1-PLACE OF DEATH St. Joseph's Hosp

Registered No.....

City of BALTIMORE: (No.....St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Hinkel

(a) Residence No. 508 N. Belmont St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~ (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 29-1905

7-AGE. 19 yrs. 7 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) C.M. Bowers
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Joseph R. Hinkel

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Matilda Paulson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Joseph R. Hinkel
(Address) 508 N. Belmont Ave

15- Filed DEC 16 1924 192 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 13/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 11, 1924 to Dec 13, 1924
that I last saw h.. alive on Dec. 13, 1924
and that death occurred, on the date stated above, at 6.05 m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (Bilateral)

(Duration) 5 yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(Duration) 6 yrs. 0 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Sybert M. D
19 (Address) W Baltimore Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL. Dec 17, 1924

20-UNDERTAKER Chas C Fuller & Son — ADDRESS 2334 Jefferson

B.—WRITE PLAINLY, with pen and ink. NAME and RESIDENCE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Belford Road (South of Maple Ave.)

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93028

CERTIFICATE OF DEATH.

101-0 D 93028

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belford Ave, near Belair Road Averlea ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Mrs.) Helen Mueller

(a) RESIDENCE NO. 6 Belford Ave, Averlea ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Mueller

6 DATE OF BIRTH (month, day, and year) April 05 1886 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38 (?)		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Klederleis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. Mueller

(Address) Averlea

15 Filed DEC 6 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14-1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1924, to Dec. 14, 1924, that I last saw h alive on Dec. 14, 1924, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (secondary) Lobar Pneumonia (Rt Lower Lob) with Bilateral Pleurisy (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

12/14, 1924 (Address) Rosedale, Balt., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	12/17/19 24
20 UNDERTAKER	ADDRESS
Geo. J. Reed, Sons	33 Hanford Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93029 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93029

CERTIFICATE OF DEATH.

Registered No. 2574

1-PLACE OF DEATH

City of BALTIMORE: (No. Woman's Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Katherine Strauss

(a) Residence No. 2437 Washington Blvd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 30 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Strauss

6-DATE OF BIRTH (month, day and year) Feb 14 1866

7-AGE. 58 yrs. 10 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. — Mathus

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Wm. Ashbaugh M.D.

(Address) 2437 Washington Blvd.

15- Robert F. Brooks

Filed ....., 192.... Registrar.

Burial Permit Clerk

DEC 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14th, 1924, to Dec. 15th, 1924, that I last saw h[illegible] alive on Dec. 15th, 1924, and that death occurred, on the date stated above, at 6:45 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation with auricular fibrillation

(Duration) ... yrs. unknown ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

Bronchitis (Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Frederick L. Snyder, M. D.

Dec 15, 1924 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. 12-17- 1924

20-UNDERTAKER. Robert Brooks & Son

ADDRESS Calhoun & Col Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ASK DO

Spec.-12-23-21—E.B.R.S.—400 Blks.

Fosmus. Fany 910 W. Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93030

CERTIFICATE OF DEATH.

90 D 93030

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4701 York Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny M. Fosmus

(a) Residence No. 4701 York Road St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella

6-DATE OF BIRTH (month, day and year) Aug 1 1859

7-AGE. 65 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Mass

PARENTS

10-NAME OF FATHER Howard Fosmus

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Not Known

12-MAIDEN NAME OF MOTHER Mary J. Mathew

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Not Known

14- (Informant) Mary E. Fosmus

(Address) 4701 York Road

15- Filed DEC 16 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 15 1924

17- I HEREBY CERTIFY, That I attended deceased from 2/15 19 24 to 12/15 19 24

that I last saw h... alive on 12/14/24 19.....

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(Duration) History 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Barnard Levy M. D.

Dec 16, 19 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL (CREMATION) OR REMOVAL. DATE OF BURIAL.

Woodlawn Dec. 17, 1924

20-UNDERTAKER. ADDRESS

Wm Cook 502 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Ferall Clark

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93031

CERTIFICATE OF DEATH.

101-001

D 93031

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet E Ruder

(a) RESIDENCE NO. 2405 Maryland Ave WARD 26 - md.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 1 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Thomas A Ruder

6 DATE OF BIRTH (month, day, and year) June 9, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Georgetown D. C.
(State or country)

PARENTS

10 NAME OF FATHER John A Wilson Chesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co - Md

12 MAIDEN NAME OF MOTHER Harriet Bellamy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgetown D. C

14 Informant (Address) University Hospital

15 FILED DEC 16 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1924, to Dec. 16, 1924, that I last saw her alive on Dec. 16, 1924, and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

(1) Lobar Pneumonia

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L Anderson M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brandywine Md Via Pmaker

DATE OF BURIAL Dec 17, 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93032

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland Gen. Hosp.

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

REGISTERED NO. 16100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Perry

(a) RESIDENCE NO. 4741 Pimlico Road ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 15 1924

7 AGE Years — Months 4 hours Days — If LESS than 1 day, ... hrs. or 4 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md Maryland Gen. Hosp.

PARENTS

10 NAME OF FATHER Nathaniel C. Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gaithersburg, Md

12 MAIDEN NAME OF MOTHER Annie B. Dexter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hamilton, Va

14 Informant Mrs Annie B. Perry

(Address) 4741 Pimlico Rd.

15 DEC 16 1924 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-15, 1924, to 12-15, 1924, that I last saw her alive on 12-15, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature separation of placenta

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of Dec 15/24

Was there an autopsy? Surgical and Clinical

What test confirmed diagnosis?

(Signed) John Washington M. D.

..... 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 12-17 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Baltimore

Burial Permit Clerk

PLEASE WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT. PHYSICIAN'S FOLLOWING should be stated EXACTLY. AGE should be carefully supplied. Exact address of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93033

CERTIFICATE OF DEATH.

11-081 93033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3230 E. Baltimore ST. 1st WARD)

2-FULL NAME Rose V. Reynolds

(a) RESIDENCE NO. 3230 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Reynolds

6 DATE OF BIRTH (month, day, and year) Feb 10-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Stoddard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Jno. V. Reynolds (Address) 3230 E. Baltimore

15 Filed DEC 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-1924

17 I HEREBY CERTIFY, That I attended deceased from 12-10, 1924 to 12-13, 1924

that I last saw h[illegible] alive on 12-12, 1924

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Com

DATE OF BURIAL 12/17, 1924

20 UNDERTAKER J. F. Moran

ADDRESS 3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

gr D 93034

1-PLACE OF DEATH Maryland Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 16 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie Shansfield

(a) RESIDENCE NO. 605 Stanley st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. W. Shansfield

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40	5.	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Upland, Pa.

PARENTS

10 NAME OF FATHER Wright Downs

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma Coppock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) del. Co. Pa.

14 Informant A. W. Shansfield

(Address) 605 Stanley st.

15 Filed DEC 17 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16/24

17

I HEREBY CERTIFY, That I attended deceased from 12/14/24, 19 to 12/16/24, 19, that I last saw her alive on 12/16/24, 19, and that death occurred, on the date stated above, at 4:40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Venous Stasis and Cerebral Edema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Thrombosis of left Lateral Sinus & Longitudinal Sinus

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 12/15/24 & 12/14/24

Was there an autopsy? yes

What test confirmed diagnosis? Clinical, laboratory

(Signed) Jno. C. Finegan, M. D.

19 (Address) M[illegible] Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Pa — DATE OF BURIAL Dec 19 1924

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-9 D 93035

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Hall Alley. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Sheckels.

(a) RESIDENCE NO. 1108 Hall Alley. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXX HUSBAND of (XXXXXXX Kate Sheckels.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oyster shucker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Benjamin Sheckels.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Jacobs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant George E. Sheckels. (son)
(Address) 405 Grindall St.

15 Filed DEC 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) & inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Pulmonary Congestion.
Exposure.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto W. Reinhardt, M. D.
(Coroner.)

Dec, 15, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL 12-17 1924

20 UNDERTAKER E. & B. Hartz ADDRESS 115 E. Hoffman St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 93036

D 93036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Sterling St ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Sheilds

(a) RESIDENCE NO 632 Sterling ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Sheilds

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Junk dealer &
(b) General nature of industry, business, or establishment in which employed (or employer) rag picker
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portland Maine

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rosa Sheilds
(Address) 632 Sterling St

15 Filed ..... 192 DEC 17 1924 ROBERT R. KRAUER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probable Lobular Pneumonia

(duration) yrs. mos. ds.

(Signed) J. S. Fuller, M. D.
(Coroner.)

12/16/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt Zion cemetery	dec 18 1924
20 UNDERTAKER Edward Bryson	ADDRESS 631 orleans st

IMPORTANT NOTICE TO UNDERTAKERS. Copy of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93037

CERTIFICATE OF DEATH.

137 D 93037

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME John Brewer

(a) RESIDENCE NO. 118 W. Durham ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Zachary Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Castilli Rousu

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record
(Address)

Filed DEC 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16/1924

17 I HEREBY CERTIFY, That I attended deceased from 11/20/24, 19..... to 12/16/24, that I last saw h— alive on 12/16/24, 19....., and that death occurred, on the date stated above, at 7.20 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate (Benign)
Renal Calculi

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Hollen, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Dec. 18th 1924

20 UNDERTAKER Tolley & Gowan & Son ADDRESS 901 Holliday St

Chas J. J. Gowan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Bateman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93038

CERTIFICATE OF DEATH.

17 D 93038

Registered No.....

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. ..... St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel B. Bateman

(a) Residence No. Orlando Ave Hamilton St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Margaret Bateman

6-DATE OF BIRTH (month, day and year) May 3, 1852

7-AGE. 72 yrs. 7 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Policeman Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Samuel D. Bateman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, Bridget Leonard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14-(Informant) Jennie Bateman

(Address) Orlando Ave Hamilton

15-DEC 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 15 1924

17-I HEREBY CERTIFY, That I attended deceased from Dec 13 1924 to Dec 15, 1924 that I last saw h..tive on Dec 15, 1924 and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis C. Hypertension

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Myocarditis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Sybert M. D

, 19 (Address) St. Jos. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mem Cathedral Cemetery — DATE OF BURIAL, Dec 18 1924

20-UNDERTAKER, C. Carson Stewart — ADDRESS 723 N. Lafayette Ave

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93039

CERTIFICATE OF DEATH.

101-001 D 93039

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N. Fremont St. Ave (WARD)

2-FULL NAME Ella Kemp

(a) RESIDENCE NO. 818 N. Fremont Ave ST. WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 74 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE, if it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James M Kemp — divorced

6 DATE OF BIRTH (month, day, and year): March 19 1850

7 AGE: Years 74 | Months 8 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hunks Town, Washington County Md

PARENTS
10 NAME OF FATHER: Daniel Sager
11 BIRTHPLACE OF FATHER (city or town) (State or country): Chewsville Pa
12 MAIDEN NAME OF MOTHER: Scharlets Harris
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chewsville Pa

14 Informant: Mrs Armenia Steger
(Address): 818 N. Fremont Ave

15 Filed DEC 7 1924, 19.. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1924, to Dec 15, 1924, that I last saw h[illegible] alive on Dec 15, 1924, and that death occurred, on the date stated above, at 11,30 a m.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Cerebral embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? renal tests

(Signed) H. E. Knipp, M. D.

12/17, 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec 18 1924

20 UNDERTAKER: C. Carson Kennard — ADDRESS: 728 W Lafayette Ave

Spec—12-23-21—B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 93040

CERTIFICATE OF DEATH.

6 129

D 93040

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 N. Broadway St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bell Stein

(a) Residence No. 312 N. Broadway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Stein

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nuper Toots

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Rose Millman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore

15- Filed DEC 17 1924 19.. ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1923 to Dec. 16, 1924

that I last saw h.. alive on Dec. 16, 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

General arterio-sclerosis

Chronic diffuse nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. G. Michelson, M. D.

, 19 (Address) 2230 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dr. Rosedale — DATE OF BURIAL. 12/17 19 24

20-UNDERTAKER. Jack Lewis — ADDRESS 1439 E. Balt.

N. B.—WRITE PLAINLY with ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 93041

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 93041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Wilmer alley ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth G. Clark

(a) RESIDENCE NO. 1032 Wilmer alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ung
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. P. Clark

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Estelle Cross

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Chas. P. Clark
(Address) 1032 Wilmer alley

15 Filed DEC 17 1924 ROBERT R. KRAUTER Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no contrib,

(duration) yrs. mos. ds.

(Signed) J. Hennessy, M. D.
(Coroner.)

Dec. 16, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Dec 18 1924

20 UNDERTAKER Joseph A Farrell ADDRESS 2319 Eas

mation should be carefully supplied. Any information which may be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93042

CERTIFICATE OF DEATH.

154-003

D 93042

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard Green ST., 13 WARD)

2-FULL NAME Baby Boy Stewart

(a) RESIDENCE NO. 1202 Falls Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1 day 8 hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... NB

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Alexander Pleasant

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Stewart

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Ella Stewart
(Address) 202 Falls Road

15 Filed ..... , 19 ..... ROBERT R. KRAUTER, Registrar

DEC 17 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1924, to Dec. 12, 1924, that I last saw h[illegible] alive on Dec. 12, 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Toxaemia—

(duration) yrs. mos. ds.

CONTRIBUTORY (Congenital absence of
(Secondary)
Sternum anterior abdominal wall)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 12-11-24

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. Alexander Morey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL DEC 16 1924

20 UNDERTAKER .....

ADDRESS .....

Commissioner Health,

Per. Wm. E. WOODALL.

DEC 17 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state name of disease as directly as possible, and all abbreviations should be carefully avoided. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

387

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161001

D 93043

REGISTERED NO. D 93043

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dix

(a) RESIDENCE NO. 1044 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1924

7 AGE — Years — Months — Days: one — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Dix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital. JOHNS HOPKINS HOSPITAL

15 Filed [illegible] 19[illegible] [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1924 to Dec. 12, 1924

that I last saw he alive on Dec. 12, 1924

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E L Stone, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

A UNDERTAKER

ADDRESS

Per. Am. [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS PAPER IS A PERMANENT RECORD. PHYSICIANS should state AGE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93044

D 93044 CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McVay

(a) RESIDENCE NO. 413 Moore st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1924

7 AGE: Years | Months | Days: one | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John McVay

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Eva Raleigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Johns Hopkins Hospital.

15 DEC 17 1924 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27 19 24 to Nov. 28 19 24

that I last saw him alive on Nov. 28 19 24

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E L Stone, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS

UNDERTAKER Commissioner of Health

DEC 17 1924

N. B.—WRITE PLAINLY, WITH INK. All items under AGE should be stated EXACTLY. PHYSICIANS should be careful that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1765-9 D 93045 100-D 93045

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., 9 WARD)

2-FULL NAME Margaret Smith

(a) RESIDENCE NO. Waverly Md ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	—	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Stanley Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Helen Gillie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL JOHNS HOPKINS HOSPITAL

15 DEC 17 1924 2950 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1924, to Dec 9, 1924, that I last saw her alive on Dec 9, 1924, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute primary pneumonia
(Bronchopneumonia)

(duration) yrs. mos 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In hosp.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Edmund N. Kerper M. D.

12/13, 19 24 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 ADDRESS 1924

20 UNDERTAKER [illegible] DEC 16 1924

Add. [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful that every item is correctly stated. EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be careful that every item is correctly stated. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93046

161-D 93046

1-PLACE OF DEATH D 93046

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Brooks

(a) RESIDENCE NO 1101 Ashland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) XXXXX

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Oscar Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Martha -------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hopkins Hospital (Address) JOHNS

15 Filed . 192 ROBERT N. KRAUTER Registrar

2049 B. P. Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity-hemorrhage rt. lateral ventricle brain-infective conjunctivitis & infected kidney.

(Autopsy at Hopkins Hospital)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [signature] (Coroner.), M. D.

12/12/24 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

Commissioner of Health, Per. Wm. E. Woodall. DEC 16 1924

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death must be supported by a statement of symptoms or by a statement that a physician was in attendance. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93047

100.00 D 93047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2121 Eastern Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Micheal Reves

(a) Residence No. 2121 Eastern Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michelina Reves

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. about 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) L. Bass Cas. Shop

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, St. Reves

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Michalina Reves

(Address) 2121 Eastern Ave

15- DEC 7 1924 Registrar.

ROBERT P. HARTLEY

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13 19.. to Dec. 15 19 24

that I last saw him alive on Dec. 15 19 24

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani M. D.

, 19 (Address) 2942 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 12/19 19 24
20-UNDERTAKER, Wm Faulkowski	ADDRESS 441 Eastern

Filed DEC 7 1924

Registrar.

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93048

D 93048

CERTIFICATE OF DEATH.

Registered No. 46

1-PLACE OF DEATH

City of BALTIMORE: (No. 217 S. Wolfe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Strzepek

(a) Residence No. 217 S. Wolfe St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Marcel Strzepek

6-DATE OF BIRTH (month, day and year): July 25 1879

7-AGE: 46 yrs. 5 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS:

10-NAME OF FATHER: Simon Polek

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Katharine Piszkiewicz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant): Catharine Strzepek

(Address): 217 S. Wolfe

15-

Filed DEC 17 1924 192.... ROBERT F. KNAPP Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 14 1924

17- I HEREBY CERTIFY, That I attended deceased from 11/10 1924 to Dec 14 1924

that I last saw h.er alive on Dec 14 1924

and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Brain Pneumonia Heart Cancer

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Ida A Dunhoff M. D.

12/15 1924 (Address) 16236 North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL, 12/18 1924

20-UNDERTAKER: Wm Fiaschetti — ADDRESS 1118 Eastern Ave

IMPORTANT. See should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Tittle

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93049

CERTIFICATE OF DEATH.

44 D 93049

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Tittle

(a) RESIDENCE NO. 771 W. Lexington ST., WARD Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Tittle

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Thomas Tittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Tittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant University Hospital (Address)

15 Filed DEC 17 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1924, to Dec 16 1924.

that I last saw him alive on Dec 16, 1924,

and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

(1) Carcinoma of the stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis chron. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L. Andersen, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec. 17 1924

20 UNDERTAKER Mc Geniss & Carroll

ADDRESS 4203 Ridgewood Ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY; FRACTIONS OF A YEAR should be stated in days; if under one day, in hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93050

188-003

D 93050

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Wilde Road near 8 St. ST., 7 WARD)

CITY OF BALTIMORE, MD.

2-FULL NAME Frank. C. Doell.

(a) RESIDENCE No 2904 E Monument ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Doell.

6 DATE OF BIRTH (month, day, and year) Feb 10-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 66
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Adam Doll.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Hohlman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Adam Doll (Address) 2904 E Monument St

15 DEC 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Accident,
Fracture of Skull.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Shock. (duration) ..... yrs. ..... mos. ..... ds.

(Signed) G C Wades, M. D.
(Corner) 12/17/24
(Address) 1436 Kenyon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Dec 18 1924

20 UNDERTAKER Lang and Zeile

ADDRESS 403 S. Mo[illegible]

IMPORTANT—Should be filled out by attending physician, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks. Frances 9/Kopp

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93051 123 D 93051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital Registered No.....

City of BALTIMORE: (No. 33rd & Calvert St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frances Kopp

(a) Residence No. 3705 Bel Air Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	married

5a-If married, widowed, or divorced, HUSBAND of (or) (WIFE) of Frederick Kopp.

6-DATE OF BIRTH (month, day and year) March 17, 1878

7-AGE.	If LESS than 1 day.
46 yrs. 8 mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Conrad Krauss

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Francis Shafer

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country).

14- (Informant) Mrs Francis Kopp
(Address) 3705 Bel Air Road

15- DEC 17 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924 to Dec 16, 1924, that I last saw h[illegible]live on Dec 16, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Infected ovarian cyst

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec 14 1924

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & operation

(Signed) Donald E. Chandler M. D.

, 19 (Address) Union Memorial Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Sacred Heart	Dec. 19, 1924

20-UNDERTAKER,	ADDRESS
Lilly & Zirkin	403 S. Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PARTICULAR OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

175536 D 93052

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 ~~D~~ 93052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., V WARD)

2-FULL NAME Charles Wheatley

(a) RESIDENCE No. 2 22 E Washington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Earl Wheatley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Clara Kuder

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant (Address) Records Johns Hopkins Hospital

15 Filed DEC 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1924, to Dec. 16, 1924, that I last saw him alive on Dec. 16, 1924, and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. ..... mos. ..... 1 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund W. Kemper, M. D.

12/16, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 19 1924
20 UNDERTAKER	ADDRESS
John McWeber	1803 Bank St

N. B.—WRITE PLAINLY, WITH INK. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should bear in mind that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93053

CERTIFICATE OF DEATH.

202 D 93053

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 Sipple Ave. ST., Sandtown WARD)

2-FULL NAME Adam J. Gehring

(a) RESIDENCE NO. 106 Sipple Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. Fill in all items. Information should be carefully supplied. AGE, OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Catherine M. Gehring.

6 DATE OF BIRTH (month, day, and year) Apr. 17 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ladies Cloak 080

(b) General nature of industry, business, or establishment in which employed (or employer) Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Gehring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Gruenewald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Catherine M Gehring

(Address) 106 Sipple Ave Eastside

15 Filed DEC 17 1924 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 15 1924

17 I HEREBY CERTIFY, That I attended deceased from DEC 14 1924 to DEC 15 1924 that I last saw h. alive on DEC 15 1924 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH was as follows:

Ruptured blood vessel intracranial hemorrhage

3 hours

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D Carre, M. D.

(Address) Carre & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 18 1924
20 UNDERTAKER	ADDRESS
Henry Hoch Son	1301 E Eager St

Spec—12-23-21—E.B.R.S.—400 Eks.

(Moosmann)

D 93054 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 57 D 93054

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. St. Josephs Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Barbara Moosmann

(a) Residence No. 1411 N. Montford Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, (HUSBAND of (or) WIFE of) the late Fanny Moosmann

6-DATE OF BIRTH (month, day and year) Jan. 3rd 1857

7-AGE. 67 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)..... 069

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. John Renner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Helen Kleiderlein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mr Joseph J. Moosmann

(Address) 1411 N. Montford Ave

15- DEC 17 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1924 to Dec. 16 1924, that I last saw her alive on Dec. 16 1924, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetic Ulcer

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys & Clin Test

(Signed) Geo B Dysart M. D

Dec. 16 1924 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL. Dec. 19 1924

20-UNDERTAKER. Henry Hoeck Son ADDRESS 1301 E Eager St

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93055

CERTIFICATE OF DEATH.

111-001 D 93055

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 E. Preston ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Zellers

(a) RESIDENCE NO. 2406 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced; (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or~~) WIFE of Nellie G. Zellers

6 DATE OF BIRTH (month, day, and year) February 23 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	52	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 061

(b) General nature of industry, business, or establishment in which employed (or employer) Police Captain

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Zellers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Nellie G. Zellers

(Address) 2406 E. Federal St

15 Filed DEC 7 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924, to Dec 16, 1924, that I last saw h... alive on Dec 16, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

Cerebral Hemorrhage

(duration) 2 yrs ... mos ... da

CONTRIBUTORY (Secondary) Ulcer of Stomach

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) W. E. Harker M. D.

Dec. 19 24 (Address) 201 N Bat St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 20 1924
20 UNDERTAKER	**ADDRESS**
Henry Hoeck Son	130 E Eager St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

D 93056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93056

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Linkeland Av. WARD 15)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugh R Berryman

(a) RESIDENCE NO. 2605 Lakeland ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	N	Maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M Coral Berryman

6 DATE OF BIRTH (month, day, and year) Oct 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tank Driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER N R Berryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Dent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Mary Aaron
(Address) 2005 Lakeland ave

15 Filed DEC 17 1924, 192.....
Robert P. Harrison, Registrar
Chief Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (Homicide)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) struck on head by auto

(duration) yrs. mos. ds.

(Signed) J. F. Hennessy, M. D.
(Coroner)

Dec. 14, 192 4 (Address) 2802 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Bur	Dec 17 1924
20 UNDERTAKER W. M. Rouzer	ADDRESS 2238 W Balto

AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE
mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

WRITE PLAINLY, with unfading ink.—

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93057

CERTIFICATE OF DEATH.

D 93057

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 12 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LeRoy Cryer

(a) RESIDENCE NO. 312 W. 31st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 19 1923

7 AGE — Years: 1 — Months: 8 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: LeRoy Cryer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Genevieve Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Weston L. Cryer
(Address) 312 W. 31st St.

15 Filed ... 1924 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15. 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-6 , 1924 , to 12-15 , 1924.

that I last saw him alive on 12-15 , 1924,

and that death occurred, on the date stated above, at 9:55 P.m.

The CAUSE OF DEATH* was as follows:

Septic Bronchopneumonia

(duration) yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary): Staphylococcic Sore throat

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony V. Buchner, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monte Marie Cem. Towson	Dec 18. 1924
UNDERTAKER	ADDRESS
Mrs Jos John W. Teufel & Son	801 W. Fayette St.

II.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

(Norwood Ave. & Belvidere Rd.)

D 93058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Johns Hopkins Hospital ST., 25 WARD)

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur W. Schoenewolf

(a) RESIDENCE NO. Norwood ave Baltimore, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 18 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Grocer 034

(b) General nature of industry, business, or establishment in which employed (or employer) John Schoenewolf

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Schoenewolf

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Francis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John Schoenewolf (Address) Norwood ave

15 DEC 17 1924 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1924, to Dec 16 1924,

that I last saw him alive on Dec 16 1924,

and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Stella Bray

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Chas. H. Locke Wright Jr. M. D.

12/16/24 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Dec 18 1924

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W Fayette ave

Information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

17740 93059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111 901 D 93059

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., VV WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry R. Stewart

(a) RESIDENCE No. 3678 W. Pratt St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records (Address) John Hopkins Hosp.

15 Robert P. Harrison, Registrar

C 17 1924 ..., 19... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 - , 1924, to Dec 14 - , 1924, that I last saw ~~him~~ alive on Dec 14 - , 1924, and that death occurred, on the date stated above, at 7.50 A. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer

(duration) 10? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 12/8/24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Brumberg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Balto

DATE OF BURIAL 12/18/1924

20 UNDERTAKER J. A. Moran

ADDRESS 200 E Baltimore

IMPORTANT: This certificate should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93060

CERTIFICATE OF DEATH.

10/22/1 ✓

10 X

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S. Caroline ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Long

(a) RESIDENCE NO. 235 S Caroline ST., ... WARD Green Valley N.C.,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 14, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamster 123

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Geo Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Stephney Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Stephney Long (Mother) (Address) 235 S Caroline St

15 Filed DEC 17 1924, 19 ..... Registrar

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1924, to Dec 14, 1924, that I last saw him alive on Dec 13, 1924, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Pleurisy & Effusion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J ..... M. D.

Dec 17 1924 (Address) 1420 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Valley NC — DATE OF BURIAL Dec 17 1924

20 UNDERTAKER Robert F. Williams — ADDRESS 1611 N Gilmor St

Robert F. Harrison,

Registrar

DEC 17 1924

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93061

D 93061

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Dellwood Ave ST., 13 WARD)

2-FULL NAME Mary E. Younker

(a) RESIDENCE NO. 1200 Dellwood Ave ST., 13 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	68	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pennsylvania

PARENTS

10 NAME OF FATHER Jacob Younker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Biff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.A. Pa.

14 Informant Mrs Nora A. Barratt
(Address) 1200 Dellwood Ave

15 Filed ..... 19 ..... Robert F. Harrison, Registrar
Burial Permit Clerk.

DEC 17 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Dec 16, 1924, that I last saw her alive on Dec 15, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lues Cerebri

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Positive Exam

(Signed) C. W. Wiedefeld M. D.

, 19 (Address) 850 E. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL Dec. 18 1924

20 UNDERTAKER Horace F. Burgee — ADDRESS 3031 Falls Rd.

Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93062

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH. St Joseph's Hospital 2nd 14 Ward)

City of BALTIMORE: (No. Baltimore St.,

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Jefferson Bawers.

(a) Residence No. 1330 W. Fayette Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 3, 1857

If LESS than 1 day.

7-AGE. 67 yrs. 5 mos. 13 ds. ....hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Freight Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). Railroad Employer

(c) Name of employer. Clark Co. Va.,

9-BIRTHPLACE (city or town) (State or Country).

PARENTS.

10-NAME OF FATHER. Jacob Bawers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Mary A. Mday

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa

11- (Informant) Mary Bawers Gallagher

(Address) 1421 W. Lanvale St.,

13-

C 1 71924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-16-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1924 to Dec. 16 1924

that I last saw him alive on Dec 16 1924

and that death occurred, on the date stated above, at 12 20 a. m.

The CAUSE OF DEATH* was as follows: Cellulitis of Left Leg

Gangrene, Crysipelas in Nature

Senile Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Residence

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. M. Rhodes (for) M. D.

19 (Address) Chambers M.D.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Marysville P.O. DATE OF BURIAL. 12-18- 1924

20-UNDERTAKER. Robert Brooks & Son ADDRESS Calhoun Holland Sts

should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93063

D 93063

CERTIFICATE OF DEATH.

74007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 E Hoffman ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William E. Johnson

(a) RESIDENCE. NO. 2035 E Hoffman ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or, ~~WIFE of~~) Elizabeth Johnston

6 DATE OF BIRTH (month, day, and year) Mar 1st 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	55	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireworker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto City Md

10 NAME OF FATHER Richard Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. City Md

12 MAIDEN NAME OF MOTHER Julia Skinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City Md

14 Informant Mrs Elizabeth Johnston
(Address) 2035 E Hoffman St

15 Filed ____, 19 Robert F. Harrison
Registrar

DEC 17 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/15 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924, to Dec 14, 1924, that I last saw h~~im~~ alive on Dec 14, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Uremic Retention, & Cardiac Degeneration

(duration) ____ yrs. 2 mos. 18 ds.

CONTRIBUTORY (Secondary) Calculus Pancreatitis & Portal Cirrhosis

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? N O Date of ____

Was there an autopsy? N O

What test confirmed diagnosis? Signs & symptoms

(Signed) Harry A Bulbeck, M. D.

12/14 '24 1924 (Address) 1625 E Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 19th 1924

20 UNDERTAKER: Peter Nicolaus 2060 Eastern Ave — ADDRESS

WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93064

CERTIFICATE OF DEATH.

D 93064

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Patapsco ave. ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Blackwire

(a) RESIDENCE No. 413 Patapsco ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick J. Blackwire

6 DATE OF BIRTH (month, day, and year) Sept. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Stallings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Tydings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Eugenia Blackwire

(Address) 413 Patapsco ave.

15 Roberts P. Harrison, M.D. Registrar

C 1 7 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9th, 1924, to Dec. 16th 1924, that I last saw he alive on Dec. 15th 1924 and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Harry Kleibel M. D.

12/17, 1924 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holley's Burying Ground Dec. 18 1924

20 UNDERTAKER — ADDRESS

Mrs. A. E. Fuller 4804 Bayford ave.

I. B. mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A K S

K O D

Cor.—1-12-23—M&T—100 Bks.

D 93065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93065

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 N. Carlton St., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt. W^m. Gunn

(a) RESIDENCE NO. 1010 N. Carlton St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza. W^m. Gunn

6 DATE OF BIRTH (month, day, and year) about 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) 010
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Eliza. W^m. Gunn
(Address) 1010 N. Carlton St.

15 Filed ..... 1924 ..... Robert P. Harrison Registrar

C 1 7 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro enteritis

acute pyo foot, (duration) ..... yrs. ..... mos. 1½ hr. ds.

CONTRIBUTORY (Secondary) no history. (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hennessy, M. D.
(Coroner.)

Dec 16, 1924 (Address) 208 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	12-15 1924
20 UNDERTAKER Sam'l W. Chase & Son	ADDRESS 1408 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

Varia 800 Blk W. Fulton. ✓

D 93066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D 93066

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2770 W. Lafayette St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Smoot

(a) Residence No. 2770 W. Lafayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin B.

6-DATE OF BIRTH (month, day and year): Oct. 25 1840

7-AGE: 84 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va

PARENTS.

10-NAME OF FATHER: Noah Baldwin

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Dorthy Sandige

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14- (Informant): Robert W. Smoot

(Address): 2770 W. Lafayette

15- Filed ..... 192 ..... Registrar.

Robert F. Harrison,
Burial Permit Clerk.

DEC 17 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 16 24

17- I HEREBY CERTIFY, That I attended deceased from for many 19 Jan 19..... that I last saw h.. alive on Dec 15 19 24 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Death was due to Chronic nephritis of years duration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) Christmyder Smith M. D

192 (Address) 847 Hunter ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 18 1924

20-UNDERTAKER: H. McCurdy — ADDRESS: 502 E. 24 St.

should be carefully supplied. Exact statement of OCCUPATION is very important. If not properly classified, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93067

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D 93067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Gilman Apt A2 (ST.) 21 W + Calvert (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A McGraw

(a) RESIDENCE NO. Cor 31st + Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 11 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~divorced~~

~~HUSBAND~~ (or) ~~Wife~~ of John McGraw

6 DATE OF BIRTH (month, day, and year) June 16 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	11	00	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER James B Mallen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Hughes

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant H H Dryden

(Address) Gilman Apt A2

15 Filed DEC 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16th 1924

17

I HEREBY CERTIFY, That I attended deceased from

Dec 15, 1924, to Dec 16, 1924.

that I last saw her alive on Dec 16, 1924,

and that death occurred, on the date stated above, at 12-02 m.

The CAUSE OF DEATH* was as follows:

Exhaustion from.

Paralysis with result of Coma.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur R Schumpert, M. D.

, 19 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 12/18, 1924

20 UNDERTAKER Geo W Jenkins & Sons Co

ADDRESS Richard McCulloh

N.B. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 93068

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

93238

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 7 WARD)

2-FULL NAME Frank Moore

(a) RESIDENCE NO. 1710 Thames ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER Geo. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Pa.

12 MAIDEN NAME OF MOTHER Amelia Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Municipal Hospital Dr. JOHNS (Address)

15 Filed DEC 18 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15-1924

17 I HEREBY CERTIFY, That I attended deceased from 11-21, 1924. to 12-15, 1924. that I last saw h[illegible] alive on 12-15, 1924. and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Right Arm

Septicemia

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude G. Johns, M. D.

12-15 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL DEC 18 1924

20 UNDERTAKER Commissioner Health, — ADDRESS [illegible]

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93069

CERTIFICATE OF DEATH.

D 93069

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1645 Ruxton ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia B. Freedman

(a) Residence No. 1645 Ruxton ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 26 1908

7-AGE. 16 yrs. mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS

10-NAME OF FATHER, Morris Freedman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Fannie Stein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Jack Lewis

(Address) 1439 E Balto St

15-

DEC 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/17/24

17- I HEREBY CERTIFY, That I attended deceased from 12/10/24 19.. to 12/17/24 19..

that I last saw her alive on 12/17/24 19..

and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Anemia of Pernicious

(Duration) yrs. mos. 1/2 ds.

18-Where was disease contracted if not at place of death? H

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Pneumonia

(Signed) Walter C Bacon M. D.

12/17 1924 (Address) 1001 E 20

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19..
Dolphin Hebrew Cem	12/19 24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Balto

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93070

CERTIFICATE OF DEATH.

74002

D 93070

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 3806 woodland ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Fannie Sacks

(a) Residence No. 3806 woodland ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis J. Sacks

6-DATE OF BIRTH (month, day and year)

7-AGE. 56 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS:

10-NAME OF FATHER. Israel Gotthelf

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Bailey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant). Jack Lewis

(Address). 1439 E Baltimore St

15- Filed DEC 18 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/16/24

17- I HEREBY CERTIFY, That I attended deceased from December 12, 1924 to December 16, 1924

that I last saw her alive on December 16 1924

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis (chronic)

several years

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Cerebral thrombosis (hemorrhage?) (Duration) yrs. mos. 6 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign & symptoms

(Signed) Frank R. Smith M. D

Dec. 17, 1924 (Address) 927 N Caba St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Nelson Hessing Rem DATE OF BURIAL. 12/18 19 24

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Baltimore St

should be carefully supplied. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 9307F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9307F

CERTIFICATE OF DEATH.

Registered No. 1001

1-PLACE OF DEATH

City of BALTIMORE: (No.) 509 N Saraloga St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bowen

(a) Residence No. 509 N Saraloga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Bowen

6-DATE OF BIRTH (month, day and year) May 17 1894

7-AGE. 32 yrs. 5 mos. 1 ds. If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stevadore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Snow Hill Md

PARENTS.

10-NAME OF FATHER George Bowen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Charlotte A Bowen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Annie Bowen (wife) (Address) 517 N Saratoga St

15- Filed DEC 18 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 16-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 19 24 to Dec 16 19 24

that I last saw him alive on Dec 16 19 24

and that death occurred, on the date stated above, at 7 A .m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Smeltzer M. D.

Dec 17 19 24 (Address) 1126 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baden Md. DATE OF BURIAL Dec 18 1924

20-UNDERTAKER. Samuel Hendley ADDRESS 1128 Edmondson Ave

Sound or Literally Exact statement of OCCUPATION is very important, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—7500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93072

CERTIFICATE OF DEATH.

100-001

D 93072

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Vincents Inf. Asylum

CITY OF BALTIMORE: (No. 1401 Division ST. 14 WARD)

2-FULL NAME Mary Fisher

(a) RESIDENCE NO. St Vincents Infant Asy. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE — Years: 1 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Vincents Infant Asy. Balto. Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eleanor Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant St Vincents Asylum (Address) 1401 Division

15 DEC 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec-1, 1924, to Dec 14, 1924, that I last saw h[illegible] alive on Dec 13, 1924, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. J. Goldsborough M. D.

, 19 (Address) 2923 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Dec 18 1924

20 UNDERTAKER Martin Burke & Son

ADDRESS 1212 North

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

that it may be properly classified. Exact statement of OCCUPA-
ns on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93073

CERTIFICATE OF DEATH.

101-001

D 93073

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Bentalou ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Christina Schlueter

(Residence in Baltimore: No. 427 S. Bentalou St.: 10 yrs.. - mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widow

6-DATE OF BIRTH, May (Month) 11 (Day), 1849 (Year)

7-AGE, 75 yrs. 7 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Hd

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Mr. - Magin

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. N. Disco

(Address) 1315 N. Char. St

15-

Filed DEC 18 1924 by ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1924, to Dec 17 1924, that I saw her alive on Dec. 16 1924, and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis, Chronic

(Duration) ? yrs. ....mos. ....ds.

(Signed) F. N. Disco M. D.

Dec 17, 1924 (Address) 1315 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ~~10~~ yrs. — mos. — ds. In the State ~~10~~ yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL Western DATE OF BURIAL, Dec 20, 1924

20-UNDERTAKER George H. Schwabe ADDRESS 1701 Pink Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D93074

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

CERTIFICATE OF DEATH.

REGISTERED NO. D93074

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucian Etzel

(a) RESIDENCE No 1024 S. 1st St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 11/24

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Julius Etzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Julius Etzel
(Address) 1024 1st St

15 Filed DEC 18 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intercranial Hemorrhage

(Autopsy at Hopkins Hospital)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Probable Meningitis (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Watts, M. D. (Coroner.)

12/18/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart [illegible] DATE OF BURIAL Dec 18 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 408 S Wolfe St

CAUSE OF DEATH. [illegible] TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93075 — 129 — D 93075

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 W Lexington ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lala May Leonard

(a) RESIDENCE. No. 2204 W Lexington ST., WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? 38 yrs. 7 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: John Henry Leonard

6 DATE OF BIRTH (month, day, and year): May-3-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm Albaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Matilda Dorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Husband) (Address): John H Leonard 2204 W Lexington St.

15 DEC 16 1924 16 RUBERT P. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec-17- 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1924, to Dec 16 1924, that I last saw she alive on Dec 16 1924, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Nephritis Parenchymatous Acute

(duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) V. Dan Williams, M. D.

, 19 (Address) 901 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec-19- 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY. Words should be stated EXACTLY. PHYSICIANS should be supplied. AGE should be carefully supplied. AGE should be carefully classified. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93076

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3541 Newland Av St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Charlotte Ward

(a) Residence No. 3541 Newland Av St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 1 mos. 9 ds How long in U. S., if of foreign birth? 32 yrs. 1 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Randall C. Ward.

6-DATE OF BIRTH (month, day and year) Nov-7-1892

7-AGE, 32 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. William F. Assau

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Hanover Germany

12-MAIDEN NAME OF MOTHER. Anna A. Lang

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Leipzig Germany

14-(Informant) Randall C. Ward - Husband

(Address) 3541 - Newland av.

15-Filed DEC 18 1924 ROBERT R. MAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 7, 1923 to Dec. 16, 1924 that I last saw her alive on Dec 14, 1924 and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 7/24

Was there an autopsy? no

What test confirmed diagnosis? Path. Exam of Tumor

(Signed) Maurice Lazarus, M. D.

Dec 17, 1924 (Address) 15 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Hill Cemetery DATE OF BURIAL. Dec. 18 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 108 W. NORTH AVE.

Exact statement of OCCUP... classified. ...may be properly ... in plain terms, so that it ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93077

CERTIFICATE OF DEATH.

91-002

6

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 401 N: Rose St St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Koester

(a) Residence No. 401 N: Rose St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Koester

6-DATE OF BIRTH (month, day and year): 10/20/1860

7-AGE: 64 yrs. I mos. I5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) Henry Koester

(Address) 401 N. Rose St

15-

Filed ROBERT L. KRAUSE

Burial Permit Clerk.

DEC 18 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/16/1924

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to Dec 15, 1924, that I last saw h[illegible] alive on Dec 14, 1924, and that death occurred, on the date stated above, at 7.00 a.m.

The CAUSE OF DEATH was as follows:

High Blood Pressure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Beall, M. D.

12/16, 1924 (Address) 3907 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. DATE OF BURIAL, Dec 18, 1924

20-UNDERTAKER: John Ulrich ADDRESS 2008 Orleans

Should be entered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93078

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2934 E. Preston St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles Russel Robinson

(a) Residence No. 2934 E Preston St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of Mildred Robinson

6-DATE OF BIRTH (month, day and year) July 27th 1876

7-AGE, 24 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman 666

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Robinson

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ida Bevans

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Baltimore Md

14- (Informant) Mrs. Ida V. Robinson

(Address) 2934 E Preston St

DEC 18 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 11th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Dec 11, 1924, that I last saw h. alive on Dec 11, 1924, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Reg. & Mitral Reg. Insufficiency

enlarged heart

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 26 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R G Davis, M. D.

, 19 (Address) 1509 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Dec. 19th 1924

20-UNDERTAKER, George Schillington — ADDRESS 1126 E Monument St

Exact statement of OCCUPATION is required. Use plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93079

CERTIFICATE OF DEATH.

167-08 D 93079

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1457 Reynolds St. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Bryan,

(a) RESIDENCE NO. 1457 Reynolds St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or ~~divorced~~
(or) WIFE of Michael Bryan.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saleslady.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

067

9 BIRTHPLACE (city or town) (State or country) Memphis, Tenn.

PARENTS

10 NAME OF FATHER William Simpson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Annie McCourt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Florence Henkle.(daughter)
(Address) 3813 Towanda Ave.

15 Filed DEC 18 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 16, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphyxia.
From a hot water heater.
Suicide.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Dec, 17th. 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Dec. 19 1924

20 UNDERTAKER Um Cook.

ADDRESS 5028 York Rd.

mation should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be written. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Edith L Cross

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93080

CERTIFICATE OF DEATH.

31 D 93080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Belvidere Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith L Cross

(a) RESIDENCE NO. 404 Belvidere Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Geo. H. Cross

6 DATE OF BIRTH (month, day, and year): Sept 4 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John M. Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dubois Md

12 MAIDEN NAME OF MOTHER: Eva L. Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Geo. H. Cross 404 Belvidere Ave

15 Filed DEC 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from August 15th, 1924, to Dec. 16th, 1924, that I last saw her alive on Dec. 16th, 1924, and that death occurred, on the date stated above, at 12 20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculose

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Elbert C. Patzel M. D.

Dec. 17, 1924 (Address) 2734 Pa. Ave. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL: Dec 20 1924

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1737 Eager

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93081 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93081

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 N Fulton Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Murphy

(a) RESIDENCE NO. 32 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life 50 yrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Terrence Murphy

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Makenron

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: W J Murphy

(Address): 632 N Fulton Ave

15 Filed DEC 19 1924 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924, to Dec 16, 1924.

that I last saw her alive on Dec 16, 1924,

and that death occurred, on the date stated above, at 6 35A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. O'Neill, M. D.

12/17, 1924 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 12/19/24

20 UNDERTAKER: George A Farley

ADDRESS: Fulton & Fayette

N. B. WHOLE ANSWERS should be carefully supplied. AGE mation should be carefully supplied. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST., 2V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo A Cooper

(a) RESIDENCE NO 526 Iceman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) March 11 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Erasmus Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlestown Md

12 MAIDEN NAME OF MOTHER Mary Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlestown Md

14 Informant Myrtle M. Myers
(Address) 526 Iceman Ave

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
DEC 18 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

.....(duration) .....yrs. .....ntos. .....ds.

(Signed) ..... , M. D.
(Coroner)
....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	12/16 1924
20 UNDERTAKER	ADDRESS
Jno. Sec'd Rogers	406 N. Conway St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93083

CERTIFICATE OF DEATH.

113 D 93083

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N Durham ST., WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Banks

(a) RESIDENCE No. 1006 Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Baby

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rosie Banks (Address) 1006 N Durham

15 DEC 18 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 17-Dec 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 — , 19 24, to Dec. 17 , 19 24

that I last saw her alive on Dec. 16 , 19 24

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Indigestion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Error in diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. Walters M. D.

, 19 (Address) 1627 Ashland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alsbury Cemetery — DATE OF BURIAL: Dec 18 1924

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS: 1715 Ashland

mation should be carefully supplied. Age, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93084

CERTIFICATE OF DEATH.

D 93084

1-PLACE OF DEATH

City of BALTIMORE, (No. 809 Edmondson Ave St. 17 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Brown

(a) Residence No. 809 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jeff Brown

6-DATE OF BIRTH (month, day and year) March 18, 1869

7-AGE. 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 16 Clinton Ave.

(c) Name of employer Mrs. Miller

9-BIRTHPLACE (city or town). Courtland Co. (State or Country). Talbot, Va.

PARENTS.

10-NAME OF FATHER, Frank Clark

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Susie Cousin

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Virginia

14-

(Informant) Mattie Richards

(Address) 809 Edmondson Ave.

15-

Filed DEC 18 1924, 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1924 to Dec 17 1924

that I last saw h[er] alive on Dec 16 1924

and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. R. Mallory M. D.

, 19 (Address) 123 Long St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Talbot, Va.	Dec 20, 19 24
20-UNDERTAKER. Mrs. Nate R Williams	ADDRESS 322 N Schroeder St.

Shall be carefully filled. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 93085

D 93085

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 White ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Wesley Kenny

(a) RESIDENCE NO. 1930 White ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb-5-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	13	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school-boy. ddd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Kenny.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Helen Irene Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Airy Md.

14 Informant Wm Kenny (Address) 1930 White St.

15 Filed DEC 18 1924 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-12- , 1924 , to 12-16- , 1924 ; that I last saw h[illegible] alive on 12-16- , 1924 ; and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Ruland, M. D.

12-16 1924 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Airy Md — DATE OF BURIAL 12/19 1924

20 UNDERTAKER Daniel Easton — ADDRESS 916 Park

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93086

CERTIFICATE OF DEATH.

101-B 93086

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Brune St. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Hanks

(a) RESIDENCE No. 702 Brune St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ben. Hanks.

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1888 (guess)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	36	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Convent Laundry

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Phillip Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama.

14 Informant Fanny Hughes
(Address) 702 Brune St.

15 DEC 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said no (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. C. Hemmeter, M. D.

Dec 15, 1924 (Coroner.) (Address) 2 W Eddon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-18-1924

20 UNDERTAKER Chas Taylor

ADDRESS Penn

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. Physician's abbreviations not permissible. Any information desired by the Registrar may be required by him before a permit is issued. Read instructions on back of certificate. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93087

CERTIFICATE OF DEATH.

15 31 D 93087

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Barrett

(a) RESIDENCE No. 2109 Cliftwood Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Shanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Reardon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address) M.T.H.

15 DEC 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to Dec. 17, 1924, that I last saw h er alive on Dec. 17, 1924, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous nephritis

(duration) yrs. Unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) J. Ekart M. D.

12-18-24 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 20 19 24
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1140 W. North Ave

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

GE should be stated in years. Exact statement of OCCUPA- at it may be properly classified. s on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93088

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 B 901

74 B 93088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (a) 2150 Boyd St., 20 Ward

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Holland

(a) Residence No. 2150 Boyd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Holland

6-DATE OF BIRTH (month, day and year) Aug. 24-1850

7-AGE, 74 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Emmg. Co. Md

PARENTS.

10-NAME OF FATHER, Benjamin Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER, Martha Howes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Geo. C. Holland.

(Address) 2150 Boyd St.

15- DEC 18 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 17th 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 8th 1924, to Dec 17th 1924

that I last saw her alive on Dec 16th 1924

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. about mos. 10 ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edith H. Morton M. D.

19- (Address) 2501 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20-PLACE OF BURIAL, CREMATION OR REMOVAL Francis Scott Cemetery DATE OF BURIAL, Dec 20 1924

21-UNDERTAKER George L. Schwartz ADDRESS 1101 Park Ave.

in plain terms, so that it may be properly classified. Exact statement of cause of death required. Follow instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93089

CERTIFICATE OF DEATH.

19 X 100-81 ✓ D 93089

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 W. Saratoga St St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Deenver Whaillain

(a) Residence No. 1510 W. Saratoga St. St., Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 Weeks yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Negro	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 4th. 1924

7-AGE. ....yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Unemployed

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Portsmouth Va.

PARENTS.

10-NAME OF FATHER. John Edgar Whallian

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Roxanna Gales

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Galesburge N.C.

14- (Informant) John Whallian

(Address) 1510 W. Saratoga St.

15- Filed ROBERT R. KRAUTER, 19.. Burial Permit Clerk. Registrar.

DEC 18 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 17th. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec.16th. 1924 to Dec. 17th. 1924

that I last saw her alive on Dec.17th. 1924

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Uncomplicated

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 4 mos. ? ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Lebanon Cem. DATE OF BURIAL. Dec-18 1924

20-UNDERTAKER. John H. Goodwin ADDRESS 1027 Druid Hill Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93090

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 S. Washington Street St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter . Rybicki

(a) Residence No. 602 S. Washington Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 4 1897

7-AGE.	If LESS than 1 day
27 yrs. 11 mos. 12 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machine Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Martin . Rybicki

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Anna Piatkowska

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country),

14- (Informant) Martin Rybicki

(Address) 602 S. Washington Street

DEC 18 1924 ROBERT K. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 16/24

17- I HEREBY CERTIFY, That I attended deceased from ~~December~~ October 15, 1923, to December 16, 1924, that I last saw ~~him~~ alive on December 16, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary),

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? clinical signs laboratory examination

(Signed) Samuel Silverstein M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Dec 20, 1924
20-UNDERTAKER,	ADDRESS
John F Weber	1803 Bank St

Should be filled. Exact statement of OCCUPATION is very important, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93091

CERTIFICATE OF DEATH.

31 D 93091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 234 Patapsco ST. Westport 25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Verna Surran

(a) RESIDENCE. (No.) 234 Patapsco (Westport) ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Fem	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 13 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Millville N.J.

PARENTS

10 NAME OF FATHER Samuel Surran

11 BIRTHPLACE OF FATHER (city or town) Millville (State or country) N.J.

12 MAIDEN NAME OF MOTHER Louella Donnelley

13 BIRTHPLACE OF MOTHER (city or town) Manchester (State or country) N.J.

14 Informant Mrs Louella Surran
(Address) 234 Patapsco St

15 Filed DEC 18 1924 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12, 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924, to Dec 17, 1924, that I last saw h.e alive on 12/17, 1924, and that death occurred, on the date stated above, at 11.8. a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Bronchitis (duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Gen Weakness (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. J. Linthicum, M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: Dec 20 1924

20 UNDERTAKER: Nelson E. Stiles

ADDRESS: 320 Md. Ave Westport

mation should be carefully answered, so that it may be properly classified. Exact statement of occupation and CAUSE OF DEATH in plain terms

Spec.—1-10-21—M&T—1500 Bks.

D 93092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 93092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Boyd ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline Schreiver

(a) RESIDENCE NO. 2102 Boyd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry A. Schreiver

6 DATE OF BIRTH (month, day, and year) 3/7/46

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Hinkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma Wilson

(Address) 2102 Boyd St.

15 Filed DEC 18 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/17/1924

17

I HEREBY CERTIFY, That I attended deceased from 9/23/20, 19..., to 12/17/24, 19..., that I last saw h[illegible] alive on 12/12/24, 19..., and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Hypertension

Diff. Nephr.

Hypercholesterinemia

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic hypertension

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard Terry, M. D.

12/17/24, 19 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec 20, 1924

20 UNDERTAKER Chas. W. Dill. — ADDRESS 3109 Frederick Ave

mation should be carefully supplied. AGE should be stated so that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93093 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93093

101-081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1031 Wilmer alley St., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Marbael

(a) RESIDENCE NO. 1031 Wilmer alley ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant W. W. Dick, Police.
(Address) Penna ave. JOHNS HOPKINS HOSPITAL

15 Filed DEC 18 1924 19 Robert P. Harrison, Registrar
2059
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Dec. 18, 1924 (Address) 202 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health, DEC 18 1924

CAUSE OF DEATH is plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 N. Robinson ST., ... WARD)

REGISTERED NO. 1227 D 93094

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Snead

(a) RESIDENCE NO. 624 N. Robinson ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Late Edward Snead

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	73	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wolford Eskridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Eskridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Spence
(Address) 624 N. Robinson St.

15 Filed DEC 8 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1924, to Nov 18, 1924, that I last saw h alive on Nov 15, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. Fisher, M. D.

12/8 1924 (Address) 1823 N. Front St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Dec. 19 1924
20 UNDERTAKER	ADDRESS
Wm. J. Hartley	116 N. Washington St.

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1626 93095

HEALTH DEPARTMENT—CITY OF BALTIMORE

93095

CERTIFICATE OF DEATH.

58-00

1-PLACE OF DEATH Johns Hopkins Hospital 12

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kelly

(a) RESIDENCE NO. 408 E. 21st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Life ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Records Johns Hopkins Hospital
(Address)

Filed 19 Robert F. Harrison, Registrar

Burial Permit Clerk

C 18 1824

mation should be carefully supplied. Age should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1924, to Dec 16, 1924, that I last saw her alive on Dec 16, 1924, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia Acute

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) J. H. Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Jos. Cemetery Texas Md	Dec 19 1924
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Guilford Av.

D 93096

1 PLACE OF DEATH

County .....

D 93096 126

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. .....

~~Village or~~ City Baltimore (No. 1810 E. Pratt St.; 2 Ward)

If death occurred in a hospital or institution give its NAME instead of street and number.

2 FULL NAME Mary A. Miskimon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: July (Month) 4 (Day) 1867 (Year)

7 AGE: 57 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Char Woman

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Dont known

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hogan Nee

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude B. Miskimon

(Address) 1810 E. Pratt St.

15

Filed DEC 18 1924

Robert P. Harrison, REGISTRAR

Burial Permit Issued by Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 16 (Day) 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924 to Dec 16, 1924

that I last saw h alive on Dec 16, 1924

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos ds

Contributory Secondary: Myocarditis

(Duration) yrs mos 7 ds

(Signed) Geo. Keller M. D.

Dec 18 1924 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs mos ds In the State yrs mos ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: Dec 19, 1924

20 UNDERTAKER: Eugene A. Moran

ADDRESS 3000 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is especially important. See instructions on back of certificate.

If more than one cause is given for death, state the one which began the fatal series first, then the second, and so on, last.

6/ Franklin St., Balto., Requesting V. S. No. 1

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93097

D 93097

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 W. Franklin ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Pinto Sr.

(a) RESIDENCE NO. 510 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Pinto Sr.

6 DATE OF BIRTH (month, day, and year): Jun - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	82.	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

145

9 BIRTHPLACE (city or town) (State or country): Termini Italy.

PARENTS

10 NAME OF FATHER: Matthew Pinto.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Catherine Borevich.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Catherine Pinto 510 W. Franklin St.

15 Filed DEC 18 1924 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-17-1924

17

I HEREBY CERTIFY, That I attended deceased from 6-20-, 1924, to 12-17-, 1924, that I last saw h[illegible] alive on 12-17-, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension, General Arterio Sclerosis, Organic mitral Stinal nephritis.t

(duration) 2 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): myocardial insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. Franco, M. D.

12-18-1924 (Address) 1004 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	DEC 19" 1924
20 UNDERTAKER	ADDRESS 2236
Wm J Hartwell	W. Baltimore St

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

KSA FEET

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 93098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93098

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 W. 34th St. St. 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie C. Coleman.

(a) RESIDENCE. No. 841 W. 34th St. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (WIFE of): Wallace Coleman

6 DATE OF BIRTH (month, day, and year): April 27/1868

7 AGE: Years 56 | Months 7. | Days 20. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city Md.

PARENTS

10 NAME OF FATHER: Charles R Hobbs.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Fannie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Wallace Coleman 841 W. 34th st.

15 Filed DEC 18 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec - 17 1924

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1924, to Dec 17, 1924, that I last saw her alive on Dec. 17, 1924, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of Uterus

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ——— Date of ———

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Davis, M. D.

12-17 1924 (Address) 800 N 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Sat Dec 20 1924
20 UNDERTAKER: Walter Davis	ADDRESS: 3307 Paige St

mation should be carefully supplied. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 93099 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93099

CERTIFICATE OF DEATH. 185

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1818 Forman ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Parker

(a) RESIDENCE No. 1818 Forman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Parker

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE: 73 | Years | Months | Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ella Peck

(Address)

15 1924 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 192X

17 I HEREBY CERTIFY, That I attended deceased from Oct-10 192X to Dec-16 192X

that I last saw h[illegible] alive on Dec 15 192X

and that death occurred, on the date stated above, at 12 PM

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broken arm

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? (Asco)

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. T. Coleman M. D.

(Address) 2036 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 12/17 1924

20 UNDERTAKER Mrs. Jas. H. Dennis

ADDRESS 1303 Presstman

Rev T. E. Nelson

mation should be carefully supplied. Exact statement of OC[illegible] may be properly classified. CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93100

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH General German Aged Home

CITY OF BALTIMORE: (No. 3 E. Cor Baltimore Hayes ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Ruhfp

(a) RESIDENCE. NO. N E Cor Balto Hayes ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17 1837

7 AGE. Years	Months	Days	If LESS than 1 day, hrs. or min.
87	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER George Ruhfp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Keaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Records of German Aged Home Baltimore Maryland

15 [illegible] 19 Registrar

EC 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1923, 19 . to Dec 17 , 1924, that I last saw h a alive on Dec. 17 , 19 , and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John L Wolff M. D.

1219 1924 (Address) 1843 W. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 19 1924
20 UNDERTAKER Joseph B. Cook	ADDRESS 1005 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

West from Harford Road South of Berwick (Ave)

Spec.—1-10-21—M&T—1500 Bks.

D 93101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maple Ave. Hamilton, Maryland WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard B. Norris

(a) RESIDENCE NO. Maple Ave. Hamilton, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Norris

11 BIRTHPLACE OF FATHER (city or town) Charles County

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara V. Smardon

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co.

(State or country) Maryland.

14 Informant William H. Norris

(Address) Maple Ave. Hamilton, Md.

C 18 1824

15 Dec 19 1924 Robert P. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1924

17

I HEREBY CERTIFY, That I attended deceased from 12/1/24, 19..., to 12/17/24, 19...

that I last saw him alive on 12/17/24, 19...

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal Meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fluid Meningitis

(Signed) Walter C. Bacon M. D.

12/17/1924 (Address) 100 E 20

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Dec 19 1924
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St.

mation should be carefully supplied. AGE should be stated in years, months and days if under 1 year, and if under 1 day, in hours or minutes. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93102

CERTIFICATE OF DEATH.

31 D 93102

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3018 Baker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine T. Montgomery

(a) Residence No. 3018 Baker St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Earl Montgomery

6-DATE OF BIRTH (month, day and year) July 18, 1900

7-AGE. 24 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Butler

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Bridget Byrne

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant)..... Edward Butler

(Address)..... 3018 Baker St

15- Dec 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924 to Dec 17, 1924

that I last saw h[illegible] alive on Dec 16 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. 17 ds.

CONTRIBUTORY (Secondary) ✓

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

12/17, 1924 (Signed) M. O'Neill M. D.

(Address) 108 N Sutton Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 20, 1924
20-UNDERTAKER Gray & Son / Edw. G. Gray	ADDRESS 701 Hollins St.

Please do not write in this space. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Consult instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93103

CERTIFICATE OF DEATH.

11-001

D 93103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Paca St ST., 25 WARD) Mt Hosp

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Miller

(a) RESIDENCE NO. 21 Paca St ST., WARD Mt Hosp

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15- 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Byrn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant W. Miller

(Address) 21 Paca st Mt Vernon

Filed DEC 19 1924 ROBERT P. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16 1924

17

I HEREBY CERTIFY, That I attended deceased from 12/14, 1924, to 12/16, 1924, that I last saw h alive on 12/16, 1924, and that death occurred, on the date stated above, at 1.09 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Grip

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert Dunn, M. D.

, 19 (Address) 1111 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 19th 19 24
20 UNDERTAKER A. Jones	ADDRESS, 111 S Gilmor St

MAKER should be careful to use correct and definite terms in describing diseases. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93104

CERTIFICATE OF DEATH.

17 D 93104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Med. Gen. Hosp ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gus Johnson

(a) RESIDENCE NO. 421 Hunt St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Horseshoer
(b) General nature of industry, business, or establishment in which employed (or employer) 036
(c) Name of employer H. L. Thomas

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hallie White
(Address) 421 Hunt St.

15 Filed DEC 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abscess of lung
Probably due to drinking
(accidental) (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Fracture of os calcis
Sustained by fall (duration) ..... yrs. ..... mos. 30 ds.

(Signed) J. O. Hennessy, M. D.
(Coroner.)

Dec. 17, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL mt. auburn cemetery

DATE OF BURIAL Dec. 18 1924

20 UNDERTAKER Edward Bryon

ADDRESS 651 orleans st

CAUSE OF DEATH must be plainly written. Any person willfully making a false statement in this certificate may be punished as provided by law. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D 93105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93105

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Stirling St ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Satterfield

(a) RESIDENCE NO 727 Stirling St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Satterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Belle Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Satterfield
(Address) 727 Stirling St

15 Filed DEC 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrage from mouth

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Probably Tuberculosis

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Wallis, M. D.
(Coroner.)

Dec 16 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	Dec 19 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1681 orleans st

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93106 CERTIFICATE OF DEATH D 93106

1-PLACE OF DEATH Bay View Hospital 25 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evans, Thos. L.

(a) Residence No 1218 Brightwood Ave Ward.....

(Usual place of abode) 24 hrs 7625 Pennington Ave (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Lola Evans

6-DATE OF BIRTH (month, day and year) Sept 6, 1878

7-AGE. 46 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Gas

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER Thomas Evans

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mollie Clarke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) Bay View Hospital

(Address) Balto Md.

15-Filed DEC 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 17, 1924

I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Dec. 17, 1924, that I last saw h.. alive on Dec 17, 1924, and that death occurred, on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Bi-necho-Pneumonia (Lung)

Duration yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis

Broncho-N's Syphilis? Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) H. J. Goldsmith M. D.

, 19 (Address) Bay View Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill — DATE OF BURIAL, Dec 22 1924

20-UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

Exact statement of occupation is required. Cause of death must be stated in plain terms, so that it may be properly classified. Physicians are requested to fill out all items, and to carefully follow instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93107

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1144 West Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Sullivan

(a) Residence No. 1144 West Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 10, 1874

7-AGE.	If LESS than 1 day,
50 yrs. 4 mos. 7 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Timothy Sullivan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Hannon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Jerry Clark

(Address) 1144 W. Fayette St.

DEC 19 1924 ROBERT B. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 10th, 19 24, to Dec 17, 19 24,

that I last saw h. alive on Dec 17, 19 24,

and that death occurred, on the date stated above, at 5.44 p.m.

The CAUSE OF DEATH* was as follows:

Ia Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Morgan M. D.

, 19 (Address) 827 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL, Dec 20, 19 24

20-UNDERTAKER John J. Fields — ADDRESS 1200 N. Eutaw St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93108

91-002

CERTIFICATE OF DEATH.

Registered No. 93108

1-PLACE OF DEATH

City of BALTIMORE: (No. 1836 W. Baltimore St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Twelbeck

(a) Residence No. 1836 W. Baltimore St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. — mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 15 1841

7-AGE. 83 yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) John G. Twelbeck.
(Address) 1502 Edgewood Road.

15- Filed DEC 19 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 17. 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 19 24 to Dec 17 19 24
that I last saw h[illegible] alive on Dec 16 19 24
and that death occurred, on the date stated above, at 6.45 A. m.
The CAUSE OF DEATH* was as follows:

Bolero Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo Koldewey, M. D.
Dec 17 1924 (Address) 1900 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Co. DATE OF BURIAL: Dec. 20. 1924

20-UNDERTAKER: Mrs. Mrs John H. Teufel & Son ADDRESS 22 W. Fayette St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 93109

D 93109

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1052 21st St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick S Payne

(a) Residence No. 1052 21st St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Gertrude Payne.

6-DATE OF BIRTH (month, day and year): June 10 1870

7-AGE: 54 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer): B. & M. 021

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): England

PARENTS.

10-NAME OF FATHER: George Payne.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Not known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14- (Informant) Gertrude Payne.

(Address) 1052 21st St

DEC 19 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 18, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1924 to Dec 18 1924

that I last saw him alive on Dec 18 1924

and that death occurred, on the date stated above, at 6.50 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Philadelphia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Sadler, M. D.

19 (Address) 2378 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 20 1924

20-UNDERTAKER: E A Wedefeldt — ADDRESS: 591 E 22 St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Use instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93110

CERTIFICATE OF DEATH.

31 D 93110

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 907 Pairce ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Downs

(a) RESIDENCE NO. 907 Pairce ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Ethel Downs

6 DATE OF BIRTH (month, day, and year) May 6, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	31	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Market House

(c) Name of employer A. Wolman

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm Henry Downs

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Harriet Jane White

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Ethel B Downs
(Address) 907 Pairce St

15 Filed DEC 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1924, to Dec. 16, 1924, that I last saw h— alive on Dec. 16, 1924, and that death occurred, on the date stated above, at 4:10 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam., Sputum Ex.

(Signed) Wm. Le Roy Berry M. D.

, 19 (Address) 1219 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 12-19-1924

20 UNDERTAKER Jno. M. Johnson — ADDRESS 1309 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93111 HEALTH DEPARTMENT—CITY OF BALTIMORE 10-001 D 93111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Thompson

(a) RESIDENCE NO. 415 Jasper ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Hayward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Shepherd

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Harry J. Duff
(Address) 420 Druid Hill Ave

Filed DEC 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-17- 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-15- , 1924, to 12-17 , 1924, that I last saw her alive on 12-17- , 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Congestive Pneumonia
Rt. Sided Hemiplegia

(duration) ..... yrs. mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler M. D.

, 19 (Address) 252 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	12-20 1924
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1309 Druid Hill Ave

mation should be entirely supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important See instructions on back of certificate.

Form—12-23-21—E.B.R.S.—400 Blks.

D 93112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93112

CERTIFICATE OF DEATH.

5 11-00

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 244 aisquith Street St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennie Michelson

(a) Residence No. 244 aisquith Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. X

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph L. Michelson

6-DATE OF BIRTH (month, day and year) Apr — 1896

7-AGE. 28 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER Bernard Banker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Bessie Racusen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Adolph L. Michelson

(Address) 244 aisquith street

15-

Filed DEC 19 1924 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16th, 1924 to Dec 19th 1924

that I last saw h[illegible] alive on Dec. 19th 1924

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Pulmonal Bronchio-pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D.A. Michelson M. D.

12/19, 19 24 (Address) 2230 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Friendship DATE OF BURIAL, 12/19/24 19..

20-UNDERTAKER, Jack Lewis ADDRESS 1439 Eutaw

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001 D 93113

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Meekins

(a) RESIDENCE NO. 153 N. Lakewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Meekins

6 DATE OF BIRTH (month, day, and year) Feb 14/05

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain of Boat

(b) General nature of industry, business, or establishment in which employed (or employer) Sailor

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Meekins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Md.

12 MAIDEN NAME OF MOTHER Ida L. Woodland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Md

14 Informant John Meekins

(Address) 153 N. Lakewood

15 Filed DEC 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1924, to Dec 17, 1924, that I last saw him alive on Dec 17, 1924, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? On Boat

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Widal & Blood

(Signed) Wm S. Love, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Island Creek Calvert Co. Md	12/20/24
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans St

mation should be carefully supplied. Any information which it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Time of burial extended to noon day afternoon Dec. 27/24 Frederick Stewart

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93114

CERTIFICATE OF DEATH.

Registered No. D 93114

1-PLACE OF DEATH

City of BALTIMORE: (No. 673 Sarah Ann St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McCormick

(a) Residence No. 673 Sarah Ann St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	Col	Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Coleman.

6-DATE OF BIRTH (month, day and year) 1868

7-AGE,	If LESS than 1 day,
56 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Stewart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Sarah Mathews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Leonard Wyburn

(Address) 673 Sarah Ann St.

15- Filed DEC 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 17/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 14, 19 24, to Dec 17, 19 24,

that I last saw h alive on Dec 15, 19 24,

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tubercular

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. T. Norwood, M. D.

Dec 19, 19 24 (Address) 1317 Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec 27 19 24
20-UNDERTAKER.	ADDRESS
M. R. C. Elliott	Fayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

93115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 93115

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 Eaton Ave ST.; 9 WARD)

2-FULL NAME Mary E. Shepard

(a) RESIDENCE. NO. 623 Eaton Ave. ST., 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of William H Shepard

6 DATE OF BIRTH (month, day, and year) 8-13-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marg. McElhaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Grace Stemmueller
(Address) 623 Eaton ave

15 Filed DEC 19 1924 ROBERT R. KRAUSER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 19 24.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1924, to Dec. 17, 1924, that I last saw h[illegible] alive on Dec. 17, 1924, and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis. Acute Cardiac Decompensation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Physical signs.

(Signed) Harold E. Wright, M. D.

12/19, 1924 (Address) 3939 Greenmount ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 20 1924
20 UNDERTAKER J. Fabian Kraus	ADDRESS 131 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93116

D 93116

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3427 Elliott St., 18th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard H. Eckhardt

(a) Residence No. 3427 Elliott St., Ward 18th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 5-1891

7-AGE. 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Eckhardt

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Connelly

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Baltimore

14- (Informant) Henry Eckhardt

(Address) 3427 Elliott St

15- FILED [illegible] Registrar.

DEC 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-17-24

17- I HEREBY CERTIFY, That I attended deceased from March 24, 1924 to Dec. 17, 1924

that I last saw h[illegible] alive on December 14 1924

and that death occurred, on the date stated above, at 4:55A.m.

The CAUSE OF DEATH* was as follows:

Paresis with Hemiplegia on the right side

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 17 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brondshaw, M. D.

12-17-, 1924 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Dec. 20, 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

In plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93117

CERTIFICATE OF DEATH.

1-001 ✓ 18-1 D 93117

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 614 N.Calvert St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy R.Cyr.

(a) RESIDENCE NO. 614 N.Calvert St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, ~~or divorced~~
~~the husband of~~
(or) WIFE of Albert Cyr.

6 DATE OF BIRTH (month, day, and year) January 28, 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Saleslady. 607
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Marcus Hook Pa.

PARENTS

10 NAME OF FATHER James McCormick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget O'Connor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sarah V.Bartow.(sister).
(Address) 16 Maple St. Marcus Hook Pa.

15 Filed ..... 19 Robert P. Harrison, Registrar

C 19 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Carbon Monoxide Poisoning,
from a lighted gas hot water heater.
Accidental Death.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt M. D.
(Coroner)

Dec. 19, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cheltenham Pa. Penna R.R. — DATE OF BURIAL Dec 19 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH must be plainly written, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

William M. Lubinski.

D 93118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93118

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Stricker ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Lubinski.

(a) RESIDENCE NO. 112 N. Stricker ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2nd, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinery Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Chesapeake Hardware Store.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Matthias Lubinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Barbara Marcki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Barbara Lubinski (Address) 112 N. Stricker St.

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18th, 1924, to Dec. 18th, 1924, that I last saw him alive on Dec. 17th, 1924, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Acute Myocardial Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical symptoms, gross

(Signed) Edw. C. Habliston M. D.

, 19 (Address) 201 E. Monument Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Dec. 22, 1924
20 UNDERTAKER M. F. Sadowski.	ADDRESS 702 S. Ann

C 19 9 1574

mation should be carefully supplied. Exact statement of OC- CPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93119

CERTIFICATE OF DEATH.

REGISTERED NO. 1610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2338 E Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Kummerle

(a) RESIDENCE No. 2338 E Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-1-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER William H. Kummerle

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)

12 MAIDEN NAME OF MOTHER Beatrice Blunck

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant William H. Kummerle
(Address) 2338 E Fayette

15 Filed DEC 19 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk. Commissioner of Health.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1924, to Dec 19, 1924, that I last saw him alive on Dec 19, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

(a) Mo. Mortation

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec 19, 1924 (Address) 1301 N Rat Rk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

DEC 19 1924

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93120

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1114 Eutaw Place St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Krasmer.

(a) Residence No. 1114 Eutaw Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lutty Betty Krasmer

6-DATE OF BIRTH (month, day and year) Oct 15-1859

7-AGE. 65 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Essen Germany.

PARENTS:
10-NAME OF FATHER, Geog Kresmer
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-
(Informant) John Krasmer
(Address) 1114 Eutaw Place

15-
Filed Dec 19 1924
Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from November 16, 1924 to December 18 1924
that I last saw him alive on December 17 1924
and that death occurred, on the date stated above, at 9 AM m.
The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Apoplexia
(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) A. H. A. Mayer M. D.
Dec 18. 1924. (Address) 2438 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
North Cordi Rocky Mount.	Dec. 19, 1924
20-UNDERTAKER.	ADDRESS
Geog. F. Ruth	1735 Hayford ave.

Exact statement of OCCUPATION is very important. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93121 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93121

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1402 Belt St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia C. Clifford

(a) Residence No. 1402 Belt St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Clifford

6-DATE OF BIRTH (month, day and year) April 9, 1846

7-AGE, 78 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto., (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John B. Roberts

11-BIRTHPLACE OF FATHER (city or town) England (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Perry

13-BIRTHPLACE OF MOTHER (city or town) Balto., (State or Country), Md.

14-Informant Geo. Jenkins

(Address) 1402 Belt St.

15-Filed Dec 9 1924 Robert P. Harrison, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 7 1924

17-I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Dec 7, 1924, that I last saw her alive on Dec 7, 1924, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Senile Myocarditis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Surgical

(Signed) E. Fletcher Ramsay M. D.

(Address) 1 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL, Dec. 20 1924

20-UNDERTAKER, Wm. or Arch. L. Fenn ADDRESS 1412 Light St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93122 ✓ D 93122

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH Bay View Hospital. 23 Registered No.

City of BALTIMORE: (No. Bay View Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hooper.

(a) Residence No. 25 E. Hamburg St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White.

5-Single, Married, ~~Widowed~~, or Divorced (write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Hooper

6-DATE OF BIRTH (month, day and year) Oct 6, 1878

7-AGE. 46 yrs. V mos. 1V ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER Charles Burkhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Philadelphia Pa.

12-MAIDEN NAME OF MOTHER Laura Jung.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14-

(Informant) Hospital Records

(Address) Bay View Hospital

15-

Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 18-1924.

17- I HEREBY CERTIFY, That I attended deceased from April 28 1924, to Dec 18 1924.

that I last saw h[illegible] alive on Dec 18 1924.

and that death occurred, on the date stated above, at 12 10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Body of Uterus
c Metastases + extension into the Vagina + Rectum

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7-27-23.

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab. Test.

(Signed) Chas. O. Chamberlain M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 20 1924
20-UNDERTAKER.	ADDRESS
J. Reynolds Lyon	14 W. Preston St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-12—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93123

CERTIFICATE OF DEATH.

D 93123

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1734 E. Lafayette St. (WARD) 18

2-FULL NAME Mamie Elizabeth Grote

(a) RESIDENCE. No. 1734 E. Lafayette Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 18 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public School Teacher.

(b) General nature of industry, business, or establishment in which employed (or employer) 568

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Frederick J. Grote

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Ramsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Ernest A. Reed

(Address) 1734 E. Lafayette Ave.

Filed Dec 9 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 — 1924, to Dec 17 — 1924, that I last saw h alive on Dec 17 — 1924, and that death occurred, on the date stated above, at 9:25 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Ch Valv Endocarditis (duration) uncert yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferies Brack M. D.

(Address) 2046 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec - 20 1924
20 UNDERTAKER	ADDRESS
H. E. Hughes	414 N. Broadway

Registrar's Stamp: DEC 9 1924

Burial Permit Clerk.

Notice: Information should be carefully supplied. Exact statement may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 93124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93124

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2430 Greenmount St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J Ray

(Residence in Baltimore: No. 2430 Greenmount Ave St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

6-DATE OF BIRTH. July 13th 1851
(Month) (Day) (Year)

7-AGE. 73 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Gone -
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Dont know

11-BIRTHPLACE OF FATHER. (State or Country). Dont know.

12-MAIDEN NAME OF MOTHER. Dont know.

13-BIRTHPLACE OF MOTHER. (State or Country). Dont know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry H Ray.

(Address) 2430 Greenmount

15- Filed OCT 9 1924 Robert F. Harrison, M.D. Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 18th 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H Morris M. D.
(Coroner.)

Dec 19 1924 (Address) 3632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetry	Dec 20 1924
20-UNDERTAKER. Wm Cook.	ADDRESS 5022 North ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of... is very important. See instructions on back of certificate.

Spec.–1-10-21 M&T 1500 Bks.

D 93125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2648 St Benedict St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Bagert

(a) RESIDENCE NO. 2648 St Benedict St. WARD Odenton Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1. yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bagert

6 DATE OF BIRTH (month, day, and year) Sept 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Severn Md

PARENTS

10 NAME OF FATHER Dennis Bagert

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Nettie Stinnett (Address) 2648 St Benedict

15 DEC 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924, to Dec 16, 1924.

That I last saw him alive on Dec 16, 1924.

And that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of Hip

Senile Cerebritis (Apoplexy)

(Duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert O Hatch M. D.

12/17, 1924 (Address) 215 Dulaney Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cem. Odenton Md.

DATE OF BURIAL Dec 20, 24

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3109 Fredk Ave.

mation should be carefully supplied. Accurate
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93126

CERTIFICATE OF DEATH.

27 184

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Greenspring & Belvedere Avenues Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D.L. Speacht

(a) Residence No. Greenspring & Belvedere Ayenues St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary C.Speacht

6-DATE OF BIRTH (month, day and year) Sept. 4,1864

7-AGE,	If LESS than 1 day,
60 yrs. 3 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town), (State or Country): Frederick County Maryland

PARENTS.

10-NAME OF FATHER: Lewis Speadht

11-BIRTHPLACE OF FATHER (city or town), (State or Country): Frederick Co. Maryland

12-MAIDEN NAME OF MOTHER: Mary E. Michael

13-BIRTHPLACE OF MOTHER (city or town), (State or Country): Frederick Co. Maryland

14- (Informant) William H.Speacht

(Address) Owings Mills P.O.Balto.Co. Md.

15- Filed ..., 192.. Registrar.

Burial Permit Clerk.

2 8 1924

In plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. Follow instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec.19,1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13 - 1924, to Dec. 19 - 1924,

that I last saw him alive on Dec. 18, 1924,

and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

Gunsal Septicemia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Slight wound of left hand infection

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James L. Ashurst, M. D.

12-20, 1924 (Address) 4012 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Frederick Md	Dec 22, 1924
20-UNDERTAKER.	ADDRESS
Jos B Cook	1023 N Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93127

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE: (No.) Dallas and Payson Sts. German Aged Home (St.) 70 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kampf.

(a) RESIDENCE. NO. German Aged Home ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 1st 1836

7 AGE — Years: 88 — Months: 2 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick Frohling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Louise Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Records. German Aged Home. Balto and Payson Sts.

15 Received ..... 19 ..... Registrar

DEC 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1924, to Dec 19, 1924,

that I last saw her alive on Dec 4th, 19..,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

7 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Artio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John L Wolff, M. D.

12-19-24 (Address) 1843 W. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Dec 20" 24

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W. Balto St.

Burial Permit Issued

MATTER printed on both sides of this paper is important. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 93128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93128

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registered No.....

2-FULL NAME Geo. Silberzahn

(a) Residence No. 601 Wyeth St. St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of May Silberzahn

6-DATE OF BIRTH (month, day and year) May 21, 1872

7-AGE. 52 yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS

10-NAME OF FATHER John Adam Silberzahn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " Maryland

12-MAIDEN NAME OF MOTHER, Mary Vetters

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), " Maryland

14- (Informant) Mrs Mary Silberzahn

(Address) 601 Wyeth St. City

15- Filed ..... 192.....

Robert T. Harrison, Registrar.

DEC 20 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 18-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 19.....to Dec 18 19.....

that I last saw h.....alive on Dec 18 19.....

and that death occurred, on the date stated above, at 1.15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

Contributory Exhaustion

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Dec 18-24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis T. Scott, M. D

12-19 1924 (Address) 601 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet — DATE OF BURIAL. Dec 22 1924

20-UNDERTAKER. Jos Block — ADDRESS 103 W Balto

Exact statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2022 Wilhelm St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos Martin Wright

(a) Residence No. 2022 Wilhelm St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. — mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Sing'l

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Dec 2, 1924

7-AGE	If LESS than 1 day
....yrs. ....mos. 17 ds.	....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse (Col)

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER Thos M Wright

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER Helen Harp

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country).....

14- (Informant) Thos M. Wright

(Address) 2022 Wilhelm St

15- Filed DEC 20 1924, 192 Robert F. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 2, 19 24, to Dec 19, 19 24, that I last saw h[illegible] alive on Dec 18, 19 24, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Wm A O'Neill M D

12/19, 1924 (Address) 108 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 20, 1924

20-UNDERTAKER	ADDRESS
John F. Denny	715 Light St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93130

D 93130

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Ashland & Lakewood Aves. St., 3 WARD)

2-FULL NAME Joseph Cappolloni

(a) RESIDENCE NO. 1215 Dought St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Cappolloni

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antoni Cappolloni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. Rose Cappolloni
(Address) 1215 Dought St

15 Filed , 192 Robert J. Harrison, Registrar
Orphans' Court.

C 2 01924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Head crushed by falling block, when derrick slipped lowering concrete sewer pipe.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Collins, M. D. (Coroner.)

12/19/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec 22 1924

20 UNDERTAKER W. H. Nicholson

ADDRESS Note 24½

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 93131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 93131

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1401 Eastern Ave. (ST.) 3 (WARD)

2-FULL NAME William Harrigan

(a) RESIDENCE No. 1401 Eastern Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor gld
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER Michael Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Hagan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Louisa Hampton

(Address) 862 Light St.

DEC 20 1924

Received ..... Robert F. Harrison, Registrar

Chief Local Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(duration) yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. ..... mos. 2 ds.

(Signed) J. C. Blades, M. D. (Coroner.)

(Address) 1426 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cem.

DATE OF BURIAL Dec 21 1924

20 UNDERTAKER Wendel Appel & Son

ADDRESS 370 Lombard

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2603 Williams Ave St., 20 Ward) 100

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa M. Meier

(a) Residence No. 2603 Williams Ave St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: W

5-Single, Married, Widowed, Divorced (write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 16, 1844

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Robert J. Meier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Teresa Tibbe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Robert J. Meier

(Address) 2603 Williams Ave

15- Filed ....., 192.

Registrar.

C 2 6 1924

Robert P. Harrison,

Vital Statistics Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 18-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 14, 19 24, to Dec 18, 19 24,

that I last saw h[illegible] alive on Dec 18, 19 24,

and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert C. Rybert M. D.

12/19/, 192[illegible] (Address) 1151 Sheldon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
New Cathedral	Dec 20, 19 24
20-UNDERTAKER.	ADDRESS
Harry H. Wetzler	153 W. Lombard St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93133

CERTIFICATE OF DEATH.

120 D 93133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Marris

(a) RESIDENCE NO. Dont Know ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Dont Know ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ft. Caroline

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address)

15 Filed DEC 20 1924 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coma Mphritis a Sunday

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) H K Gundrum M. D.
(Coroner.)

12 20, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilson N. Co. DATE OF BURIAL 12/20 1924

20 UNDERTAKER Harry A Witzke ADDRESS 1431 W. Lombard St.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93134

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Lang

(a) RESIDENCE No. 810 Mantiola ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lang.

6 DATE OF BIRTH (month, day, and year) June 11, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Clara Dotzen 1219 Scott St

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

DEC 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 18 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 12 - 6 - 1924, to 12 - 18 - 1924, that I last saw her alive on 12 - 18 - 1924, and that death occurred, on the date stated above, at 11 55 0 m.

The CAUSE OF DEATH* was as follows:

Chr. Intestinal Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Parr, M. D.

12/19/, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec 22 1924
20 UNDERTAKER	ADDRESS
Lowbook	502 E Hoffman

mation should be carefully supplied. AGE should be stated EXACTLY. If less than one year, state months, days, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93135 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93135

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1706 W. Cario St. St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Dyson

(a) Residence No. 1706 Carios St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Negro

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 2nd. 1924

7-AGE: ....yrs. 10 mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Turner Dyson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): St. Marys Co. Md.

12-MAIDEN NAME OF MOTHER: Iola Peters

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md.

14- (Informant): Iola Peters (Mother)

(Address): 1706 Cario St.

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 19th. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 18th. 1924 to Dec. 19th. 1924

That I last saw her alive on Dec. 19th. 1924

and that death occurred, on the date stated above, at 5:00 am

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. 6 mos. ....ds.

18-Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — DATE OF BURIAL: Dec 22, 1924

20-UNDERTAKER: Joseph A Lively — ADDRESS: 151 Watson ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1433 Lawrence St., ... Ward)

Registered No. 1299

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James. Halley

(a) Residence No. 1433 Lawrence St., ... Ward ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna Halley

6-DATE OF BIRTH (month, day and year) Dec 1-1850

7-AGE. 74 yrs. ... mos. 18 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer ...

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS

10-NAME OF FATHER, Patrick Halley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) John P. Halley

(Address) 1433 Lawrence

15- Dec 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1924 to Dec 19 1924

that I last saw him alive on Dec 18 1924

and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Metrel Regurgitation
Decompensated

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(Duration) ... yrs. ... mos. 14 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens M. D

12/14 1924 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Mass Cathedral	Dec 22
20-UNDERTAKER Chas. L. Stevens	ADDRESS 1501 E Fort Ave

Classified. Exact statement of OCCUPATION is very important. Use plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1816 Walbrook Ave. (ST.) 15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma K. Bossler

(a) RESIDENCE NO. 1816 Walbrook Ave ST. WARD York Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow Wm J. Bossler

6 DATE OF BIRTH (month, day, and year) —

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Rovelties
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Schimann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chambersburg Pa

12 MAIDEN NAME OF MOTHER Susan Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Celara Latterman
(Address) 42 East Maple Pa

15 Filed DEC 20 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Dec. 19, 1924 (Address) 2802 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 12/20/1924

20 UNDERTAKER H. Lester Weber

ADDRESS 2503 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of Disease is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2230 Mura St., 8 Ward) 129

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert George Bill

(a) Residence No. 2230 Mura St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Genieve Bill

6-DATE OF BIRTH (month, day and year) Dec 5th 1859

7-AGE. 65 yrs. 0 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Sugar Refinery

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). England

PARENTS.

10-NAME OF FATHER. Geo. Bill

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Elizabeth Dellow

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) Mrs Genieve Bill

(Address) 2230 Mura st

15- Filed. By Robert P. Harrison, Registrar.

DEC 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from November 3, 1924, to December 18 1924, that I last saw him alive on December 17, 1924, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Palpation, taste.

(Signed) Albert Lingenfelter, M. D.

12/19/1924 (Address) 1613 E. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bonaventure Presbyterian. DATE OF BURIAL. 12/20/24

20-UNDERTAKER. Geo. Weber & Son ADDRESS 2503 Edmondson Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 E Eager ST., 10 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Simmel

(a) RESIDENCE NO. 1107 E Eager ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? 73 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anthony Simmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Bauk (nee)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Anthony R. Simmel

(Address) 1107 E Eager St

15 Filed DEC 20 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924, to Dec 18, 1924 that I last saw h alive on Dec 17, 1924, and that death occurred, on the date stated above, at 9:25 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Fibrillation)

(duration) yrs. 1 mos ds.

Pulmonary Hypostasis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Simmel, M. D.

(Address) 4 W Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 22 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1401 E Eager St

mation should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21--E B R.S.--400 Bks.

D 93140 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93140

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE (No. 830 S Sharp St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josiah Jones

(a) Residence No. 830 S Sharp St., 22 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Col.

5-Single, Married, ~~Widowed~~ or ~~Divorced~~, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Jones

6-DATE OF BIRTH (month, day and year) July 14 1878

7-AGE, 46 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer Int'l Motor Truck Co.

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.
10-NAME OF FATHER, Thomas Jones.
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md
12-MAIDEN NAME OF MOTHER, Rebecca Galloway
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14-INFORMANT (Informant) Mary E. Jones
(Address) 830 S Sharp St.

15-DEC 20 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/17/24

17- I HEREBY CERTIFY, That I attended deceased from 12/15/24 to 12/17/24
that I last saw him alive on 12/17/24 and that death occurred, on the date stated above, at 11:50 A m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia,
(Duration) 2 yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Acute Bronchitis
Pleurisy (Duration) about 5 yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? none
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. Jones Coale, M. D.
, 19 (Address) 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Dec 21 1924

20-UNDERTAKER, J. R. Brown & Son — ADDRESS Lafayette Ave

Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93141

CERTIFICATE OF DEATH.

5-00!

74 33141

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1305 N. Bond St. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME NeDora Barnes

(a) Residence No. 1305 N. Bond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) ----------

7-AGE. About 70 yrs. - mos. - ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Co., Md.

PARENTS.

10-NAME OF FATHER William Barnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Co., Md.

12-MAIDEN NAME OF MOTHER Susan Duval

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Co., Md.

14- (Informant) Mrs. A. P. Duval

(Address) 2013 Cecil Ave.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

C 20 1924

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/18/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 11, 1924, to Dec 15, 1924, that I last saw h[illegible] alive on Dec 15 1924, and that death occurred, on the date stated above, at 2:10 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 1/2 hour

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion & Weak Heart (Duration) about one hour mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) R G Davis, M. D.

, 19 (Address) 1509 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Union Chapel, Harford Co. DATE OF BURIAL. 12/20 1924

20-UNDERTAKER. H. W. Mears & Son, ADDRESS 805 N. Calvert St.

E. Exact statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93142

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Gilmor ST., 16 WARD)

2-FULL NAME James D. Scott

(a) RESIDENCE NO. 917 N. Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Scott

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Gainyard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Ethel Gainyard
(Address) 917 Gilmor St.

15 Filed ..... 19 ..... Registrar Robert P. Harrison,
Burial Permit Clerk.

C 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17th, 1924, to Dec 19th, 1924, that I last saw him alive on Dec. 19th, 1924, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Asst. Phil ..., M. D.

12-23-1924 (Address) 1224 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Auburn	Dec 23 1924
20 UNDERTAKER Sam'l. H. Chase Son	ADDRESS 1400 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. If under one day, HOURS and MINUTES should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93143

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 319 N. Stricker St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Cristella More (Moore)

(a) Residence No. 319 N. Stricker St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ? mos.? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Femame

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 24th. 1903

7-AGE, 20 yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: unemployed

9-BIRTHPLACE (city or town) (State or Country), Loudoun Co. Va.

PARENTS.

10-NAME OF FATHER, Walter More

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Loudoun Co Va.

12-MAIDEN NAME OF MOTHER, Martha Hayman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Loudoun Co. Va.

14- (Informant) Nannie Cooper (Sister)

(Address) 319 N. Stricker St

15- Filed ....., 192.. Robert P. Harrison, Registrar.

C 2 D 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 18th. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 18th. 1924 to Dec 18th. 1924, that I last saw her alive on Dec. 18th. 1924, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

reliable

Unable to get history as to duration of disease (Duration) yrs. 1? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson, M. D.

12-19-1924 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lynchburg Va

DATE OF BURIAL, Dec 22, 1924

20-UNDERTAKER: Sam'l W. Carter Son

ADDRESS: 1400 Madison

If not delivered in 8 days, apply to Registrar for a permit.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Fill in all items, and see that instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

93144

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 93144

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 931 Shields Pl St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Johnson

(a) Residence No. 931 Shields Pl St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Johnson

6-DATE OF BIRTH (month, day and year) unknown 1864

7-AGE. 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. homework

(b) General nature of industry, business, or establishment in which employed (or employer). 670

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Essex, Va.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) John Ware

(Address) 1632 Eaton St. Phila, Pa.

15- Robert F. Harrison, Registrar.

DEC 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 13, 1924 to Dec 17, 1924

that I last saw her alive on Dec 17, 1924

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Easley M. D.

, 19 (Address) 703 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. National Cemetery

DATE OF BURIAL. Dec 2[illegible], 1924.

20-UNDERTAKER. Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

Should be carefully filled. Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93145

D 93145

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Dolphin ST.) (17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Missouri Washington

(a) RESIDENCE. NO. 607 Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George O. Washington

6 DATE OF BIRTH (month, day, and year) March 10, 1868

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Culpeper Co. Va.

PARENTS

10 NAME OF FATHER Charles Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Culpeper Co. Va.

12 MAIDEN NAME OF MOTHER Maria Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Culpeper Co. Va.

14 Informant: James Garrison
(Address) 322 Pine St.

15 Filed ....., 19.....

Robert P. Harrison Registrar

DEC 20 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 19 24

17 I HEREBY CERTIFY, That I attended deceased fr... Dec 7, 19 24, to Dec, 19 24, that I last saw h... alive on Dec 17, 19 24, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 713 Sonoma St.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) W. H. Wright, M. D.

(Address) 1209 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 20 1924

20 UNDERTAKER Samuel F. Grady

ADDRESS 1125 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 93146

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

141 D 93146

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 794 W Saratoga ST. 4 WARD)

2 FULL NAME Sarah Smith

(Residence in Baltimore: No. 708 W Saratoga St.: 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Unknown (Month) (Day), 1862 (Year)

7 AGE: 62 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Annie Franklin

(Address) 708 W Saratoga St

15

Robert P. Harrison,
Registrar
Burial Permit Clerk.

DEC 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 18 (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924 to Dec 18 1924 that I saw h[er] alive on Dec 17, 1924 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endometritis
Acute

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) L. S. Hamburger M. D.

Dec 26, 1924 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Dec 20 1924

20 UNDERTAKER: Samuel F. Grasby | ADDRESS: 1128 Mt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93147

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 403 East 23 St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Cohen

(a) Residence No. 463 East 23 St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Fannie Cohen

6-DATE OF BIRTH (month, day and year) Dec 30 1855

7-AGE, 69 yrs. 11 mos. 18 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer) Preaching the Gospel

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER Samuel Cohen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Fannie Roberts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Jane Cohen

(Address) 1330 Druid Hill Ave

15- Robert P. Harrison,

Registrar.

DEC 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924 to Dec 18, 1924

that I last saw h[illegible] alive on Dec 18 1924

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

Chronic Interstitial

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Evidence

(Signed) R. Garland Griffith M. D.

Dec 19, 1924 (Address) 1534 - D. St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Fairmount Cloud Cemetery	Dec 21st 1924
20-UNDERTAKER,	ADDRESS
Chas. E. Bomberger	Fallston Md.

Should be accurately filled. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93148 **HEALTH DEPARTMENT—CITY OF BALTIMORE** B 93148

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Magnolia Ave. Hamilton ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Mitchell

(a) RESIDENCE No. 7 Magnolia Ave. Hamilton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Mitchell

6 DATE OF BIRTH (month, day, and year) June 27, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Joseph Sullivan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah A Sterling

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Emma M. Mitchell
(Address) 7 Magnolia Ave. Hamilton.

15 Filed DEC 20 1924, 19 Robert P. Hamilton, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1924, to Dec 18, 1924, that I last saw h[illegible] alive on Dec 18, 1924, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Diphtheria (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Stanley Long, M. D.

(Address) 2712 Hartford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 20 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93149 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93149

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 618 W Cross St., 21 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna E. Loos

(a) Residence No. 618 W. Cross St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Louis A. Loos

6-DATE OF BIRTH (month, day and year): Sept 29th 1855

7-AGE: 69 yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germy.

PARENTS:
10-NAME OF FATHER: Weiss
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germy.
12-MAIDEN NAME OF MOTHER: Elizabeth Roll
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germy

14 (Informant): Louis A. Loos
(Address): 618 W. Cross st

15 Filed DEC 20 1924 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from November 30th 1924 to December 8th 1924, that I last saw he/r alive on December 16th 1924, and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

Probable Duration yrs. mos. ds.

CONTRIBUTORY (Secondary): Dilatation of Heart
(Duration) yrs. mos. One ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

17/18/1924 (Signed) J. W. Brown M. D. (Address) 1938 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Dec 22nd 1924

20-UNDERTAKER: E. Schloman & Son ADDRESS 1039 Hanover

Hanover

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. Calvert & 33rd St., 15 Ward) 185 Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James William Hall

(a) Residence No. 3605 Harrison Blvd St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Rebecca Hall

6-DATE OF BIRTH (month, day and year) June 26, 1865

7-AGE 59 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mill Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS:

10-NAME OF FATHER, Jas W Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Adaline Baird

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-Informant, W. J. Hall

(Address) 3605 Harrison Blvd

15-Filed DEC 20 1924 Robert F. Harrison, Registrar.

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 24 to Dec 19 24, that I last saw h.. alive on Dec 19 24, and that death occurred, on the date stated above, at 10:55 a.m.

The CAUSE OF DEATH* was as follows:

Fracture 12th Thoracic Vertebra

H. H. Dr. John J. Morrissey

Coroner

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Decubitus ulcers

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? Not stated

Did no operation precede death? No Date of

Was there no autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Donald C. Spamer M. D.

19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Sevry Court House Va — DATE OF BURIAL, Dec 21 1924

20-UNDERTAKER, Wm Pickue & Sons — ADDRESS Penna Ave

Exact statement of OCCUPATION is very important. Should be carefully supplied. Use words in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 93151 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93151

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 216 Hawthorne Road 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Sisco

(a) Residence No. 216 Hawthorne Road St., Roland Park Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John E. Sisco

6-DATE OF BIRTH (month, day and year) Oct 5 1840

7-AGE. 84 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto md

PARENTS

10-NAME OF FATHER, John B. Frey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Sarah A. Bowes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Spencer E. Sisco

(Address) 216 Hawthorne Road

15- Filed DEC 20 1924 19.. Robert P. Harrison, Registrar Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 19/24

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to Dec 19 1924

that I last saw her alive on Dec 18 1924

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho.

(Duration) yrs. 4½ mos. ds

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C. Clark M. D

Dec 20, 1924 (Address) Latrobe Opants

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge DATE OF BURIAL, Dec 22. 1924

20-UNDERTAKER, John Quitschelfeldt ADDRESS 58 W. Fayette

Should be carefully applied. Use ditto marks. Exact statement of OCCUPATION is very important. Should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.-400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 93152

D 93152

CERTIFICATE OF DEATH.

Registered No. 161-000

1-PLACE OF DEATH

City of BALTIMORE: (No. 3201 Strickland St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl William Finch

(a) Residence No. 3201 Strickland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
m	w	X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 18 1924

7-AGE. — 10 hrs

.....yrs. .....mos. .....ds.

If LESS than 1 day, 10 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ——— Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) 3201 Strickland St. (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, William J Finch

11-BIRTHPLACE OF FATHER (city or town) City (State or Country),

12-MAIDEN NAME OF MOTHER, Sofia Irene Kolbe

13-BIRTHPLACE OF MOTHER (city or town) City (State or Country)

14- (Informant) Mrs L Finch St

(Address) 3201 Strickland St

15- Filed DEC 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1924 to Dec 19 1924

that I last saw him alive on Dec 18 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

10 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) R. O. P. + forceps delivery

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Forceps Date of Dec 18 24

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Barnett E Carlson M. D

19 (Address) 1604 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Dec 20th 1924

20-UNDERTAKER, F. B. Wappert ADDRESS 1850 N. Bullo St

Exact statement of OCCUPATION is very important. Medical Certificate of Death must be filled in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

Dr. Ed. Benson

HEALTH DEPARTMENT—CITY OF BALTIMORE 93153

93153

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1200 Oakhurst ST., 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Harry Fenner

(a) RESIDENCE No. 1200 Oakhurst ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lydia Pearce

6 DATE OF BIRTH (month, day, and year): June 30-1871

7 AGE: Years 53 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Lard Broker

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Rev. H. Fenner

11 BIRTHPLACE OF FATHER (City or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Mary Lurby

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Baltimore

14 Informant (Address): Lydia Pearce 1200 Oakhurst

Burial permit issued Dec 22 1924 Robert F. Harrison, Registrar

Undertaker: F. B. Wisepert Address: 2855 W. Balto

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 26th, 1924, to Dec 17th, 1924, that I last saw him alive on Dec 17th, 1924, and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spine

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & course of disease

(Signed) Edw. H. Benson, M. D.

Dec 19th 1924 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Dec 22 1924

20 UNDERTAKER: F. B. Wisepert ADDRESS: 2850 W. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93154

CERTIFICATE OF DEATH

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

2-FULL NAME Charlotte McPhillimy

(a) RESIDENCE NO. 710 E. 30th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md

PARENTS

10 NAME OF FATHER James McPhillimy

11 BIRTHPLACE OF FATHER (city or town) Phila (State or country) Pa

12 MAIDEN NAME OF MOTHER Gertrude Lafferty 12/20/1924

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant James McPhillimy (Address) 710 E 30 St

15 Filed DEC 20 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1924, to Dec 20, 1924, that I last saw her alive on Dec 20, 1924, and that death occurred, on the date stated above, at 10:55 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, tonsillar & pharyngeal

(duration) yrs. — mos 16 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10+ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B Macpherson, M. D.

(Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL 12/20/24

20 UNDERTAKER Geo. J. Ruth ADDRESS 1736 Hanford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day or an hour, the EXACT number of hours or minutes should be stated, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93155 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 931 S. Ellwood Ave St., 1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roselie T. Nickel

(a) Residence No. 931 S. Ellwood av St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 20-1924

7-AGE. — yrs. — mos. 29 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto, Md.

PARENTS:
10-NAME OF FATHER: Earl Nickel
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto, Md.
12-MAIDEN NAME OF MOTHER: Minna Braunschweiger
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant): Minnie Nickel
(Address) 931 S. Ellwood av

15- Filed ..... 19.. Robert P. Harrison, Registrar.

C 201924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 19-1924

17- I HEREBY CERTIFY, That I attended deceased from December 10 1924 to December 19 1924
that I last saw her alive on December 18 1924
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:
Injected Breast Abscess, left

(Duration) — yrs. mos. 9 ds.
CONTRIBUTORY (Secondary): Myocardial Insufficiency
(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Sign
(Signed) D. B. Brownlow M. D
12-19, 1924 (Address) 3037 Odonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec. 22 1924
20-UNDERTAKER	**ADDRESS**
Zirkler & Zirkler	1739 E. Eager St.

Should be carefully supplied. Exact statement of OCCUPATION is very important. Use only such terms as are in general use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93156

CERTIFICATE OF DEATH.

38 D 93156

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Braxton

(a) RESIDENCE NO 306 S Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Orderly
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Johns Hopkins Hospital

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James H. Braxton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary ANN Bevans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles Braxton (Bro)
(Address) 519 Baker St

15 Filed DEC 21 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Autopsy at Hopkins Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphillos

(duration) 20 yrs. mos. ds.

(Signed) J S H Collins, M. D.
(Coroner.)

12/20 1924 (Address) 508 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., 4 ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Halberton Wharf. Accomac Co. Va

DATE OF BURIAL Dec 21/24 1924

20 UNDERTAKER Leonard Whallen 673

ADDRESS Sarah Ann St

Leonard Whallen

TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93157

CERTIFICATE OF DEATH.

+90 D 93157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. Madison ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance Norwell

(a) RESIDENCE NO. 211 W. Madison ST., WARD 9 Lawyers Hill Howard Co.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Charleston, S.C.

PARENTS

10 NAME OF FATHER John Norwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston S.C.

12 MAIDEN NAME OF MOTHER Sarah Wigfall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston S.C.

14 Informant Mrs Chas Pearson
(Address) Berkeley Springs, W. Va

15 Filed DEC 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1924, to Dec 19, 1924.

that I last saw her alive on Dec 19, 1924,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 211 W. Madison St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? chest signs

(Signed) B B Brumbaugh M. D.

12/19/1924 (Address) Elkridge, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston S.C. DATE OF BURIAL Dec 21 1924

20 UNDERTAKER Henry W. Jenkins ADDRESS McCulloh & Orchard Sts Baltimore Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 93158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

2-FULL NAME Celia Miller

(a) RESIDENCE NO. 2029 Eagle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel Miller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Emma —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Israel Miller

(Address) 2029 Eagle Street

15 Filed DEC 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-25, 1924, to 12-20, 1924.

that I last saw her alive on 12-20, 1924.

and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) bronchio-pneumonia

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Isidor L. Frey, M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mortimer Circle Cem. DATE OF BURIAL 12/22/1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Belvedere

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93159

CERTIFICATE OF DEATH.

90

D 93159

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 106 N. Chester St 6 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ida Broger

(a) Residence No. 106 N. Chester St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Harry Broger

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 75 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant). Morris Weimer

(Address) 106 N. Chester, C.K.

15- Filed. OCT 21 1924 19.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/20/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19 20 to Dec 19 1924 that I last saw h.. alive on Dec 19 1924 and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

12/20, 1924 (Signed) H. H. Hoffman M. D.
(Address) 1615 N. Rentalown St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Royal	Dec 21 19 24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E. Balto

Should be carefully supplied. Also should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-0-21—M&T—1500 Blks.

Potter notified

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93160

1-PLACE OF DEATH D 93160

REGISTERED NO. 1

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 18 WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose P. Lotkin

(a) RESIDENCE NO. 532 W. Balt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Plotkin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isidor J. Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Plotkin

(Address) 532 W. Balto st

15 Filed DEC 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1924, to Dec. 20, 1924, that I last saw her alive on Dec. 20, 1924, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? N-o Date of

Was there an autopsy? N-o

What test confirmed diagnosis? Clinical Lab.

(Signed) Isidore J. Levy, M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12/21 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 114 E Balto st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93161

CERTIFICATE OF DEATH.

D 93161

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3914 Liberty Heights Ave ST. 16 WARD)

2-FULL NAME Elizabeth Lee Waldeck

(a) RESIDENCE NO. 3914 Liberty Heights St., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Waldeck

6 DATE OF BIRTH (month, day, and year): April 10, 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: William H. Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Betty C. Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisonburg Va

14 Informant: Mr. John W. Waldeck
(Address) 3914 Liberty Heights Ave

15 Filed DEC 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Kennedy, M. D.
(Coroner.)
Dec. 27, 1924 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 22 1924

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 217 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93162

CERTIFICATE OF DEATH.

31

D 93162

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1913 Druid Hill Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Clark

(a) Residence No. 1913 Druid Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Florence Clark

6-DATE OF BIRTH (month, day and year) Nov 1904

7-AGE. 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS

10-NAME OF FATHER, Major Clark

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N.C.

12-MAIDEN NAME OF MOTHER, Hanna Jordan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N.C.

14-

(Informant) Florence Clark

(Address) 1913 Druid Hill Ave

15-

Filed DEC 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Glerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 19 24 to Dec 19 19 24

that I last saw him alive on Dec 18 19 24

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

12/20, 1924 (Signed) H E McCaul M. D.

(Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL, Dec. 21 1924

20-UNDERTAKER, John H. Jordan ADDRESS 1827 Druid Hill Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93163

CERTIFICATE OF DEATH.

D 93163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1513 Light St. WARD 24

2-FULL NAME Florence Omega Long

(a) RESIDENCE NO. 1513 Light St. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar Long

6 DATE OF BIRTH (month, day, and year) Jan 20, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Asheville N C

PARENTS

10 NAME OF FATHER James H. Revis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Asheville N.C.

12 MAIDEN NAME OF MOTHER Della Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Asheville N.C.

14 Informant Edgar Long (Address) 1513 Light St.

15 Filed DEC 21 1924 ROBERT P. KRAUTER, Registrar (Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1924, to Dec 20, 1924, that I last saw h er alive on Dec 20, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia following Influenza

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Dec. 21 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL 12/22 1924

20 UNDERTAKER J. Frew McCully

ADDRESS E. Fay

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Ries

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93164

CERTIFICATE OF DEATH.

113 D 93164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3900 Foster ST., H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon G. Ries

(a) RESIDENCE No 3900 Foster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER George F. Ries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harpers Ferry Va

14 Informant George F. Ries
(Address) West Virginia

15 Filed DEC 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:—

Entero-Colitis

(Duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Exhaustion (Duration) yrs. mos. ds.

12/24/24 (Signed) G E Hodes, M. D. (Coroner) 1924 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinewood Cemetery	12/20/1924
20 UNDERTAKER Geo. Weber & Son	ADDRESS 2513 Edmondson Ave

NOTE—Physician to print legibly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93165

CERTIFICATE OF DEATH.

101-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Weber

(a) RESIDENCE NO. 5201 Liberty Hghts. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Mr. P. J. Loock

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER John D. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Warren Jeffords

(Address) Chattanooga Tenn

15 DEC 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19-1924

17

I HEREBY CERTIFY, That I attended deceased from 12-16-, 1924, to 12-19-, 1924, that I last saw h[illegible] alive on 12-19, 1924, and that death occurred, on the date stated above, at 5[illegible] A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Bilateral)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) H. F. Barr, M. D.

12/19/, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chicago Ill	Dec 22nd 24
20 UNDERTAKER Wm J Tickner Sons	ADDRESS North Ave

MATTERS to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 16307
93166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+122-002

D 93166

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ben W Parks

(a) RESIDENCE NO. Port Arthur Texas ST., WARD Texas.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaret D. Parks

6 DATE OF BIRTH (month, day, and year) Aug 16 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER James Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Mattie Adair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Records
(Address)

15 DEC 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit District

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1924, to Dec 21st, 1924.

that I last saw him alive on Dec 21st, 1924,

and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Atrophic cirrhosis of Liver

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) Years mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Chas. H. Lochridge M. D.

(Address) Johns Hopkins Hospital 12/22/24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beaumont Texas	Dec 24 1924
20 UNDERTAKER Lerzo & Scott	ADDRESS 2700 Edmondson

over

FILM

Spec.—1-10-21—M&T—1500 Blks.

D 93167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Lombard St. Harford Road. WARD)

REGISTERED NO. 179 D 93167

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Dolan.

(a) RESIDENCE No. Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara G. Dolan

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER John Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Phoebe A Dehaven

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Barbara G. Dehaven

(Address) Emmorton Harford Co Md

15 FILED DEC 21 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/24

17 I HEREBY CERTIFY, That I attended deceased from 12/18/24 to 12/19/24.

that I last saw h[illegible]ive on 12/19/24

and that death occurred, on the date stated above, at 7.00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Pericarditis — Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Kelly, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmorton Harford Co Md — DATE OF BURIAL Dec 22. 1924

20 UNDERTAKER Walter Davis — ADDRESS 330 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. 93168

1-PLACE OF DEATH

City of BALTIMORE: (No. 1816 W. Franklin St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Madeleine Kernan

(a) Residence No. 1816 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) June 25, 1918

7-AGE. 6 yrs. 5 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William J. Kernan

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Blanche Wade

13-BIRTHPLACE OF MOTHER (city or town) Charles Co. (State or Country), Md.

14- (Informant) Mrs. William J. Kernan

(Address) 1816 W. Franklin St.

15- Filed DEC 21 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/20/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1924 to Dec. 20 1924, that I last saw h-- alive on Dec. 20, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Death was due to Typhoid fever,

(Duration) .... yrs. .... mos. 2 3 ds.

CONTRIBUTORY (Secondary) .... (Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? .... Date of ....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lindsay LeVaun, M. D.

, 19 (Address) 824 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 12/23, 1924

20-UNDERTAKER. Henry W. Myers & Son

ADDRESS 805 N. Calvert St.

THE PHYSICIAN SHOULD FILL IN THIS CERTIFICATE. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

93169

D ~~33219~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93169

D 93219

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hosp. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Felix Danko ~~Robert E.~~ Daniels (Danko)

S. of T. Russia

(a) Residence No. 220 Stay St., Roxbury Ward

1/20/25 (Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 19 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Builders

(b) General nature of industry, business, or establishment in which employed (or employer). 016

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Hospital Records

(Address) Home Calvert 2997

15- Filed DEC 27 1924 ROBERT E. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-22-24

17- I HEREBY CERTIFY, That I attended deceased from 11 A.M. Dec 22 19 24 to 2:30 P.M. 12-22 19 24

that I last saw h[illegible] alive on Dec 22 19 24

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. F. Rivera M. D.

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wilkes Barre Pa. DATE OF BURIAL. 12-23 1924

20-UNDERTAKER. James Dignan & Son ADDRESS 1000 E Pratt St

Should be clearly supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR, state in hours or minutes. If LESS than one day, state in hours or minutes. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93170

CERTIFICATE OF DEATH.

100-001 D 93170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 730 Doner St. ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar McLeod

(a) RESIDENCE NO. 730 Doner St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Ollie McLeod.

11 BIRTHPLACE OF FATHER (city or town) S. Carolina.
(State or country)

12 MAIDEN NAME OF MOTHER Hickson

13 BIRTHPLACE OF MOTHER (city or town) S. Carolina.
(State or country)

14 Informant Ollie McLeod.
(Address) 730 Doner St

15 Filed DEC 22 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1924, to Dec. 20, 1924, that I last saw him alive on Dec. 19, 1924, and that death occurred, on the date stated above, at 4:45 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M L Freidinger M. D.

12/24/24 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet cemetery DATE OF BURIAL Dec 22 1924

20 UNDERTAKER Edward Bryon ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93171

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 93171

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 429 Title Building.

CITY OF BALTIMORE: (No. St. Paul & Lexington Sts. ST., 16 WARD)

2-FULL NAME Francis A. McKewin.

(a) RESIDENCE NO. 1023 Ashburton St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed~~ or ~~divorced~~
HUSBAND of
(~~WIFE~~ of) Lottie E. McKewin.

6 DATE OF BIRTH (month, day, and year) June 5, 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	6	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Washburn Crosby Co.

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William I. McKewin.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Alice P. Brown.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore, Md.

14 Informant Lottie E. McKewin. (wife)
(Address) 1023 Ashburton St.

15 Filed DEC 22 1924 192 ROBERT R. WINEFORD Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.
Acute Cardiac Dilatation..

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

Dec 21st. 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	12/23/1924
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93172 — 4 + 38 — D 93172

1-PLACE OF DEATH Steamer State of Maryland. REGISTERED NO.

CITY OF BALTIMORE: (No. Pier 10 Light St. Wharf. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Tibbs.(C)

(a) RESIDENCE NO. Stevensville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. 3. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ella Tibbs.(C)

6 DATE OF BIRTH (month, day, and year) February 15, 1894.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pantryman.
(b) General nature of industry, business, or establishment in which employed (or employer): Stmr. State of Md.
(c) Name of employer: Bay Line.

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: Frank Tibbs.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Harriett.----(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia.

14 Informant: Ella Tibbs.(C) wife.
(Address): Stevensville Md.

15 Filed DEC 22 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 17, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner)

Dec. 20th. 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec 23 1924
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	17 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1746 93173 D 93173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbert Hunt

(a) RESIDENCE No. 1911 E. Biddle St., WARD Towson Point

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Spencer Pain Taylor Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Nettie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS

15 Filed DEC 22 1924 16 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 17, 1924 to Dec 20, 1924.

that I last saw him alive on Dec 20, 1924.

and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edmund H. Kerper, M. D.

12/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Dec 22 1924

20 UNDERTAKER: Mc R. G. Edwards — ADDRESS: 1727 Eastland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93174

CERTIFICATE OF DEATH.

17 D 93174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 234 N. Stricker St. 19 WARD)

2-FULL NAME Calvin T. Wagner

(a) RESIDENCE NO 234 N. Stricker St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marie E. Wagner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) in Bethlehem Steel Co
(c) Name of employer Lynch & Sutton Place

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Marie E. Wagner
(Address) 234 N. Stricker St.

15 Filed DEC 22 1924 Registrar

ROBERT R. KRAUSER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)
The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

(duration) yrs. mos. ds. Shot self in head at once

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Thos B. Norton M. D.
(Coroner.)
Dec 22nd 1924 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Lukes Cemetery Kurtistown, Md.	12/22 1924
20 UNDERTAKER Mrs Jas H. Dennis & Jr T. E. Nolan	ADDRESS 1303 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93175

CERTIFICATE OF DEATH.

11-001 D 93175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2745 Maryland Ave ST., 12 WARD)

2-FULL NAME William Tilden Baylies

(a) RESIDENCE No. 2745 Maryland Ave ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? 77 yrs. 6 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Grant Baylies

6 DATE OF BIRTH (month, day, and year) May-29-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Baylies

11 BIRTHPLACE OF FATHER (city or town) Deiton
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Susan Stone

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr Jas. E Hooper (Grand Son)
(Address) Ruxton Md

15 Filed DEC 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-21 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17th, 1924, to Dec 21st, 1924, that I last saw h[illegible] alive on Dec. 20th, 1924, and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Robert Rudisill, M. D.

Dec 24 1924 (Address) 2111 Kingsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec. 22 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93176

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1101 E. Preston Street) (Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Caplan

(a) Residence No. 1101 East Preston Street (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ada Caplan

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 43 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Leib F. Caplan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 E. Baltimore St

15-

Filed ..... 192.. ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/22/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1924 to Dec 21 1924

that I last saw him alive on Dec 21 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F Block, M. D.

Dec 22 1924 (Address) 28 E Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Hebrew Rodelph	12-27 1924
20-UNDERTAKER.	ADDRESS
Jack Levis	1439 E Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 93177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93177

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjiman Miller

(a) Residence No. 116 Augusta ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Miller

6-DATE OF BIRTH (month, day and year) 1828

7-AGE. 96 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work old aged

(b) General nature of industry, business, or establishment in which employed (or employer) work

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Mary L. Miller

(Address) 209 So. Gay St

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/24/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 21st 1924 to Dec 21st 1924

that I last saw h.. alive on ..... 19.....

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) senn.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob L. Weinman M. D.

12 21, 1924 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Friendship Cem	12/27/24
20-UNDERTAKER.	ADDRESS
Jack Levis	1439 E Balt St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 93178

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2525 Fait Ave. ST., 1 WARD)

2-FULL NAME James A. Miskimon

(a) RESIDENCE No. 2525 Fait Ave. ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1st 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles A. Miskimon

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. McCarrick

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Charles A. Miskimon
(Address) 705 S. Linwood Ave.

15 Filed DEC 22 1924 192 ROBERT R. KRAUSER, Burial Permit Clerk. Remarks:

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) J C Radcliffe, M. D.

(Coroner)

12/20/24 (Address) 1436 Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Dec. 22 1924
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93179 — 1-PLACE OF DEATH — 185 — D 93179 Registered No.

City of BALTIMORE: (No. 1002 Pennington St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaretha Lunn

(a) Residence No. 1002 Pennington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Lunn

6-DATE OF BIRTH (month, day and year) Dec. 5, 52

7-AGE. 75 yrs. mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) Germany (State or Country),

PARENTS.

10-NAME OF FATHER, John Reuker

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14-

(Informant) Wm. Schaefer

(Address) 1002 Pennington Ave

15-

Filed DEC 22 1924 JOSEPH P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19/1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1924 to Dec 19 1924

that I last saw h[illegible] alive on Dec 18 1924

and that death occurred, on the date stated above, at 7 40 m.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Fractured Femur

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Hubbard Hospital M. D.

, 19 (Address) 1320 St Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Dec. 22, 1924

20-UNDERTAKER, Margaret D. Flynn ADDRESS 1432 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 93180 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93180

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 113 S Payson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna K. Nagel

(a) RESIDENCE. NO. 113 S Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

3a If married, widowed, or divorced (or) WIFE of John Nagel

6 DATE OF BIRTH (month, day, and year) Feb 7-1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Zwick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. A. Elizabeth Landecki
(Address) 113 S. Payson St

15 Filed DEC 22 1924 19 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1923. to Dec 20. 1924.
that I last saw h alive on Dec 19. 1924.
and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

Chronic yrs. 2 mos. da.
CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) Acute yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Harwood Kahl, M. D.

1924 (Address) 2022 Wood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec. 22 1924

20 UNDERTAKER George L. Schwab ADDRESS 1401 Fulton Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93181 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93181

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Aaron Rosenstock,

(a) Residence No. Frederick, Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Rosenstock

6-DATE OF BIRTH (month, day and year) Jan 26, 1856.

7-AGE. 68 yrs. 10 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Packing Co. Farm Products

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Rosenstock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Adelaide Lowenstein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hospital Record

(Address)

15- Filed DEC 2 1924 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 20, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16 1924 to Dec 20 1924 that I last saw h[illegible] alive on Dec. 20 1924 and that death occurred, on the date stated above, at 6 45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs, Hypertension

Arteriosclerosis (Duration) Yrs yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Laboratory Studies.

What test confirmed diagnosis?

(Signed) A. Austin Peatre M. D.

, 19 (Address) Union Mem Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem DATE OF BURIAL 12/22/ 1924

20-UNDERTAKER David Sondheim ADDRESS 118-20 W. Mt. Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93182 — CERTIFICATE OF DEATH. — 100-001 — D 93182

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Leander Theres Jr

(a) RESIDENCE NO. 1631 N. Fremont ST., WARD Baltimore
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Electrical

(c) Name of employer C&P Telephone Co

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Jacob Leander Theres, Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown, Md

12 MAIDEN NAME OF MOTHER Rosalie Sherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant University Hospital
(Address)

15 Filed DEC 2 1924, 19 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1924, to Dec 20, 1924, that I last saw h alive on Dec 20, 1924, and that death occurred, on the date stated above, at 10.05 P m.

The CAUSE OF DEATH* was as follows:

(1) Broncho-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Cerebral Embolism (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L. Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pisgah Cemetery, La Plata, Md — DATE OF BURIAL: Dec 23 1924

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. Monument

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 93183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93183

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1604 Webster St St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Columbia Woodward

(a) Residence No. 1604 Webster St St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX f. | 4-COLOR OR RACE, w. | 5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Woodward

6-DATE OF BIRTH (month, day and year) May 9 1868

7-AGE. 56 yrs. 7 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Wm Mackenthum

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Christina Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Clara Cook

(Address) 205 Poplar Ave

15- Filed DEC 22 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1924 to Dec 19 1924 that I last saw h[er] alive on Dec 19 1924 and that death occurred, on the date stated above, at 2:10 A m.

The CAUSE OF DEATH* was as follows:

Acute cardiac ~~dilatation~~ decompensation

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) bronchial asthma, chronic bronchitis & mitral regurgitation ?

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Polcarro M. D

19 (Address) 2124 Ashland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Antrim — DATE OF BURIAL. Dec. 23 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E N. Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Blks.

Dr Hess
5000 Greenmount

D 93184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-0 D 93184

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 623 E 35th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Stuck

(a) Residence No. 623 E 35th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Stuck

6-DATE OF BIRTH (month, day and year) May 28 1856

7-AGE. 68 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, James Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Sarah Tucker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Joseph Stuck
(Address) 623 E 35th

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

DEC 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 21 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1924 to Dec 21 1924 that I last saw h.. alive on Dec 20 1924 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) yrs. 1 mos. 6 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Hess M. D

12-21. 1924 (Address) 5600 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood. DATE OF BURIAL. Dec 23 1924

20-UNDERTAKER. Wm Cook. ADDRESS 502 E North ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 93185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Geid. Hosp. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Foster

(a) RESIDENCE NO. 608 Walter Meyers Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. O. Foster

6 DATE OF BIRTH (month, day, and year) May 13, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	40	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John A. Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rebecca Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Patrick (Address) 1608 Walter Meyers Court.

15 Filed DEC 24 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/21/24 19

17

I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1924, to 12/21/24, 19....., that I last saw her alive on 12/21/24, 19....., and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

adeno-Carcinoma

of Rectum.

(duration) yrs. 14 mos ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb 25, 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical laboratory

(Signed) H. O. Stemple M. D.

19 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Dec 23 1924

20 UNDERTAKER Wm. Cook — ADDRESS 502 E. Fort Ave.

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93186

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Mullen

(a) Residence No. 413 W 24th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mullen

6-DATE OF BIRTH (month, day and year) Dec 18 1859

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Thomas Mullen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mime Yaiger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Municipal Hospital Bureau

(Address)

15- Filed ..... 192 ROBERT R. KRAUTER Registrar.

DEC 22 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-19-24

17- I HEREBY CERTIFY, That I attended deceased from 11-15, 1924, to 12-19, 1924, that I last saw him alive on 12-19, 1924, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude G. Hunt, M. D.

12-20, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary, Hampden — DATE OF BURIAL, Dec 22, 1924

20-UNDERTAKER, W. C. Cook — ADDRESS 502 E Fayette Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. B Woods 26 N Gilmore.

D 93187

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

D 93187
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2703 Harlem Av St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Silverwood

(a) Residence No. 2703 Harlem Av St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 9 1850

7-AGE. 74 yrs. 1 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Silverwood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Mary Sadler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Mrs. J. Bruchon

(Address) 2703 Harlem Ave

15-

Filed 192 ROBERT R. KRAUTER, Registrar.

DEC 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 13, 1924, to Dec 19, 1924, that I last saw h[illegible] alive on Dec 19, 1924, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 36 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) few yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Bruun and Ford M. D.

Dec 20 1924 (Address) 626 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. Dec 24 1924

20-UNDERTAKER. Harman Cook & Estate ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93188

CERTIFICATE OF DEATH.

D 93188

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) B.V. Hospital ST., (WARD) 10

2-FULL NAME Vincent R. Sheckells

(a) RESIDENCE NO. 711 Brown ST., WARD Lansdowne

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Steel
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Vincent R Sheckells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katherine Reiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm H. Sheckells
(Address) Lansdowne Md

15 Filed DEC 22 1924 ROBERT R. KRAMER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Alcoholism

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

(Signed) G C Bladen M. D.
(Coroner.)

M.D. (Address) 1436 Eutaw Bmy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 12/23 1924

20 UNDERTAKER Wm Cook — ADDRESS 511 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bk. Alma S. Kolseth

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93189 — CERTIFICATE OF DEATH. — 13 74 — D 93189

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 W. North Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Alma Stevens Kolseth

(a) Residence No..... 728 W. North Ave. St.,..... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Henry S. Kolseth

6-DATE OF BIRTH (month, day and year): December 14, 1865

7-AGE: 79 yrs. ..... mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Vermont

PARENTS.

10-NAME OF FATHER, Robert Stevens

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Vermont

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Vermont

14- (Informant) Harry L. Kolseth M.D.

(Address) 728 W. North Ave.

15- Filed DEC 22 1924 ROBERT R. KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924, to Dec 20, 1924, that I last saw h.. alive on Dec 18, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Elmer B Freeman M. D.

, 19 (Address) 417 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Manchester N.H. — DATE OF BURIAL, Dec 22 1924

20-UNDERTAKER, Harry A. Weitzel — ADDRESS 5314 W. Lombard

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93190

CERTIFICATE OF DEATH.

D 93190

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: No. St Joseph's Hosp St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Willey

(a) Residence No. 1645 N. Spring St. Ward St Michaels Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE W

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie W Willey

6-DATE OF BIRTH (month, day and year) Sept 27-1862

7-AGE 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country) St Michaels Md

PARENTS

10-NAME OF FATHER Charles W Willey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) St Michaels Md

12-MAIDEN NAME OF MOTHER Sarah Jewell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Talbot Co Md

14-Informant Fannie W Willey

(Address) 1645 N. Spring St.

15-Filed DEC 22 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1924 to Dec 20 1924

that I last saw him alive on Dec 20 1924

and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Pyloric end of the Stomach

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 20/24

Was there an autopsy? No

What test confirmed diagnosis? Clin and X Ray Exam.

(Signed) Geo B. Dyer M. D

19 (Address) St Joseph's Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Bells Cemetery	Dec 23 24
UNDERTAKER	ADDRESS
Todd & Reinhardt	42 N. Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93191

CERTIFICATE OF DEATH.

No 179

1-PLACE OF DEATH

City of BALTIMORE: (No.) 7700 O. Donnell (Ward) 26

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Le Brun

(a) Residence No. 7700 O. Donnell (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma Ludwig

6-DATE OF BIRTH (month, day and year) Aug 17-1852

7-AGE. 72 yrs. 4 mos. 4 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Florist

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Henry A Le Brun

11-BIRTHPLACE OF FATHER (city or town) (State or Country). France

12-MAIDEN NAME OF MOTHER. Mary J Marquett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). France

14-

(Informant) Mrs. Emma Le Brun

(Address) 7700 O. Donnell

15-

DEC 22 1924

ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 21/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Dec 21 1924

that I last saw him alive on Dec 21 1924

and that death occurred, on the date stated above, at 10 00 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Haemoplegia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Kidney Blood Poison (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H L Sadler M. D.

Dec 24, 1924 (Address) 3326 Bull St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem

DATE OF BURIAL. Dec 24 1924

20-UNDERTAKER. John Ullrich

ADDRESS 2108 Aliceanna

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73 D 93192

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 228 N. Luzerne Ave. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Ernest Pettig

(a) Residence No..... 228 N. Luzerne Ave. St., ... Ward 6th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 72 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Caroline Pettig

6-DATE OF BIRTH (month, day and year) 3/3/1856

7-AGE, 68 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) Hanover (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) Hanover (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Johanah Pettig

13-BIRTHPLACE OF MOTHER (city or town) Hanover (State or Country), Germany

14- (Informant) Mrs. Martha Thoron

(Address) 228 N. Luzerne Ave.

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

DEC 27 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/21/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept ..... 1924, to Dec 21 ..... 1924, that I last saw him alive on Dec 20 ..... 1924, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(Duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Alfred H. Goodrich M. D.

Dec 26, 1924 (Address) 8 E. Pattison Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL, Dec 29, 19..

20-UNDERTAKER: John Ellrich — ADDRESS: 2008 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

D 93193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 93193

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Crist

(a) RESIDENCE NO. 1426 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1924

7 AGE — Years: — Months: — Days: — If LESS than 1 day, 4 hrs. or ... min.: 4 Hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Crist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER May Boteler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed DEC 22 1924 ROBT. R. CARTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1924, to Dec. 17, 1924, that I last saw him alive on Dec. 17, 1924, and that death occurred, on the date stated above, at 11 10 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E L Stone, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner of Health, DEC 22 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93194

CERTIFICATE OF DEATH.

12/ D 93194

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. Hebrew Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie B. Rubel

(a) RESIDENCE NO. 2214 E. Biddle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND ~~of~~ (or) WIFE of: Daniel B. Rubel

6 DATE OF BIRTH (month, day, and year): June 7th 1867

7 AGE: Years 57 | Months 6 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Susanna Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Daniel B. Rubel

(Address): 2214 E Biddle St

15 Filed DEC 22 1924 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-15-24, 19..., to 12-20, 19 24, that I last saw h.. alive on 12-20, 19 24, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 6 mos ....ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) ....yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy?

What test confirmed diagnosis? Clinical & Laboratory Evs.

(Signed) Isidor I. Levy, M. D.

Dec, 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Baltimore Cemetery — DATE OF BURIAL: Dec 24 1924

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

93195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Patterson Park Ave ST., 7 WARD)

2-FULL NAME Annie M. Thiell

(a) RESIDENCE No. 808 N. Patterson Park Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Thiell

6 DATE OF BIRTH (month, day, and year) Nov. 8th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	57	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Walter

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lankam

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country) Germany

14 Informant William C. Thiell (Address) 808 N. Patterson Park Ave.

15 Filed DEC 2 21924 19 ROBERT R. KRAMER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1924, to Dec 20, 1924, that I last saw h.. alive on Dec 5th, 1924, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease.

Mrs Thiel was attended by Dr W. G. Speer Dec. 6 to Dec 20 in my stead. See last saw her Dec 18 '24]

(duration) 5+ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. S. Watson, M. D.

Dec 20 1924 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels Cemetery	Dec. 23 1924
20 UNDERTAKER	ADDRESS
Fredk Lasalm & Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93196

1-PLACE OF DEATH Garage Rear

CITY OF BALTIMORE: (No.) 1310 W Lexington St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren R. Corey

(a) RESIDENCE NO 404 N. Carey St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Wm R. Corey

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lottie Blackwell Lottie Blount

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lottie Hobler
(Address) 404 N. Carey St

15 Filed C 2 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Monoxide Gas Poisoning

(duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Dec 22nd, 1924 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
In place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec 22 1924
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Hart St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93197

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 2916 McElderry St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Ruth Sigmund

(a) Residence No.... 2916 McElderry St., Ward.....
(Usual place of above)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 24 1924

7-AGE. ....yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Raymond Sigmund

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Eva Haisbeck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Raymond Sigmund

(Address) 2916 McElderry St

15- DEC 21 1924 Robert P. Harrison, 192... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 21/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 18, 1924 to Dec 21, 1924

that I last saw h[illegible] alive on Dec 20 1924

and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Lev. Heller M. D.

12. 22 1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Dec 22 1924
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Pleasant St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Impor... See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93198

D 93198

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Barger or Bamba

(a) RESIDENCE No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jacob Barger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Harriet Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Municipal Hospital Records
(Address)

15 Dec 21 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-18, 1924, to 12-21, 1924, that I last saw her alive on 12-21, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative);
Myocardial Insufficiency
(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Adenoma of Thyroid
(duration) 6 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lst.

(Signed) Claude G. Draper M. D.

(Address) 12-22 1924 Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel	12/24 1924
20 UNDERTAKER	ADDRESS
Edw. Cook	502 E. Lexington

DEC 22 1924

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St., 13 WARD)

REGISTERED NO. 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Glick

(a) RESIDENCE No. 2424 Callow Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Sigmund Glick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rumania

12 MAIDEN NAME OF MOTHER Tillie Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hosp. Records (Address)

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

C 21024

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1924, to Dec 22, 1924.

that I last saw him alive on Dec 22, 1924

and that death occurred, on the date stated above, at 3:03 a.m.

The CAUSE OF DEATH* was as follows:

Tonsillar & Laryn. Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Postive Culture

(Signed) Myron B. Tull, M. D.

12/22/24 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bklyn. Hebrew — DATE OF BURIAL 12-22 1924

20 UNDERTAKER Jack Levin, Hall & Levin — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICI CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See instructions on back of certificates. CUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93200

CERTIFICATE OF DEATH.

D 93200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Timberlake

(a) RESIDENCE NO. Lutherville Baltimore Co. Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Va

PARENTS

10 NAME OF FATHER Francis Timberlake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Blaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Municipal Hospital Records (Address)

15 Filed DEC 22 1924, 19 Robert F. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 22 1924

17

I HEREBY CERTIFY, That I attended deceased from 11 - 9, 1924, to 12 - 22, 1924, that I last saw him alive on 12 - 21, 1924, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma (Soft Parts of Right Arm) & Generalized Metastasis (duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Path.

(Signed) Claude G. Jones, M. D.

12-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Dec 27 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93201

CERTIFICATE OF DEATH.

X 15-002 V

93201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Oakhurst Place ST.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Francis Verney

(Residence in Baltimore: No. 1216 Oakhurst Place St.; ....yrs. 11 mos. ....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Nov. 21, 1844 (Month) (Day) (Year)

7-AGE, 80 yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home duties
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frederick Browne

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louisa Fork

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia Short

(Address) 1216 Oakhurst Place

15-

Filed....., 192.. Robert P. Harrison, Registrar.

DEC 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924, to Dec 21 1924, that I saw h[er] alive on Dec 14 1924, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) yrs. 11 mos. ....ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. ....mos. ....ds.

(Signed) Chas A Davis M. D.

Dec 21 1924 (Address) 1108 Brookfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Howard Co Md

19-PLACE OF BURIAL OR REMOVAL, Mount View Cemetery Howard Co Md. — DATE OF BURIAL, Dec 23, 1924

20-UNDERTAKER Scott M. Starr — ADDRESS Md. Ellicott City

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1029 Edmondson ave St. 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Edna E McGill

(a) Residence No... 1029 Edmondson ave St. ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): married

5a-If married, widowed, or divorced ~~Husband~~ of (or) WIFE: Harry F McGill

6-DATE OF BIRTH (month, day and year): May 17 1891

7-AGE: 33 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS:
10-NAME OF FATHER: John W Ward
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto
12-MAIDEN NAME OF MOTHER: Elizabeth A Allen
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): MD

14-Informant: Elizabeth Ward
(Address) 1029 Edmondson ave

15-Filed ... 192... Robert P. Harrison, Registrar.

DEC 22 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 21-24

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1923 to Dec 21 1924

that I last saw her alive on Dec 21 1924

and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) Over 1 yrs. and 2 weeks

CONTRIBUTORY (Secondary): None

(Duration) - yrs. - mos. - ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Harry F McGill M. D.

Dec 21, 1921 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hemb — DATE OF BURIAL: Dec 23, 1924

20-UNDERTAKER: Chenoweth & Son — ADDRESS: 3617 Chestnut Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 93203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93203

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520½ N. Mount ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Dorman

(a) RESIDENCE NO. 520½ N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Birdie Dorman

6 DATE OF BIRTH (month, day, and year) ? ? 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	37	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Birdie Dorman

(Address) 520½ N. Mount St.

15 Filed C 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924 to Dec 20, 1924 that I last saw him alive on Dec 19, 1924 and that death occurred, on the date stated above, at 2.04 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) Probably 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. H. Hayland M. D.

12/22/24 (Address) 1149 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 12/28/24

20 UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93204

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 93204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Vogel

(a) RESIDENCE NO. 2540 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widow

6 DATE OF BIRTH (month, day, and year) Sept. 2 / 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER Louis Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Buckingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Liverpool England

14 Informant Mr. Walter Vogel

(Address) 2540 E. Fayette

15 Filed DEC 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1924, to Dec. 20, 1924, that I last saw h[illegible] alive on Dec. 20, 1924, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Gangrene

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. M. Edwards, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Dec. 23 1924

20 UNDERTAKER: Jos. J. Kerr & Son — ADDRESS: 1506 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93205

D 93205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Stanley

(a) RESIDENCE NO 1812 E. Madison St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lucy? Stanley

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Esther Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Johns Hopkins Hospital
(Address)

15 Filed DEC 2 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute uremia-Urethral stricture-
Hydro nephritis& ureter
(Autopsy at Hopkins Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Haller, M. D.
(Coroner.)

Dec 20/24 192 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	12-22 192 4
20 UNDERTAKER	ADDRESS
E & B Hearn	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 93206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Cathedral ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Boyne

(a) RESIDENCE NO. 703 Cathedral ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Boyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Alley Commongs (Address) 15 W Mulberry St

15 Filed DEC 22 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 , 19 .. , to Dec 21 , 19 24 ,

that I last saw h.. alive on Dec 21st , 19 24 ,

and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Peri Rectal Abscess

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 1 '24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas E Bonner, M. D.

Dec 24, 19 24 (Address) 51 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL Dec 24 19 24

20 UNDERTAKER Henry W Jenkins & Son ADDRESS Oakland Md

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Sadie Mildred Young)

D 93207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93207

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Hampden ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Mildred Young

(a) RESIDENCE NO. 832 Hampden ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-08

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elijah W. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sadie Brooks Dec'd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A.Co Md

14 Informant Elijah W. Young

(Address) 832 Hampden Ave

15 Filed ..... 19 .....

Robert P. Harrison,

Registrar

Burial Permit Clerk.

DEC 2 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-20-1924

17

I HEREBY CERTIFY, That I attended deceased from Dec-11-, 1924, to Dec-20, 1924

that I last saw h[illegible] alive on Dec-20-, 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Coleman M. D.

(Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 23 1924
20 UNDERTAKER Sam'l H. Chase & Son	ADDRESS 1430 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size—12-23-21—E.B.R.S.—400 Blks.

D 93208

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 93208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3115 Oakfield Ave (St.) 1st (Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Louisa Bross

(a) Residence No. 3115 Oakfield Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 6 1867

7-AGE. 57 yrs. 0 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jacob Bross

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Kate Stieff

13-BIRTHPLACE OF MOTHER (city or town) Mayerstown
(State or Country), Pa.

14-

(Informant) Mrs. Wm Rasmers

(Address) 3115 Oakfield Ave

15-

Filed DEC 22 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1924 to Dec 20, 1924

that I last saw h[illegible] alive on Dec 20th 1924

and that death occurred, on the date stated above, at 7.45 P.m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings.

(Signed) Herbert E Beeke M. D.

12/22, 1924 (Address) 3048 N. Monroe Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem — DATE OF BURIAL. Dec 23 1924

20-UNDERTAKER. Wm Jeckne & Sons — ADDRESS Norfolk Va.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93209

CERTIFICATE OF DEATH.

× 154-001

D 93209

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Donald Simmers

(a) Residence No..... Port Deposit, Md. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 24, 1924.

7-AGE.	If LESS than 1 day.
0 yrs. 6 mos. 30 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (Infant)

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Port Deposit, Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Mr. Carroll Simmers

11-BIRTHPLACE OF FATHER (city or town)..... Port Deposit, Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Muriel Jackson

13-BIRTHPLACE OF MOTHER (city or town)..... Port Deposit, Md.
(State or Country),

14- (Informant) Mr. John Simmers

(Address) 622 Brookline

15- Filed DEC 23 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 10 1924 to December 23 1924

that I last saw him alive on December 23 1924

and that death occurred, on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:

Intracranial hydrocephalus.

(Duration) 0 yrs. 2 mos. ? ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of Dec. 22, 1924

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) O B Price M. D.

, 19 (Address) Union Memorial Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Port Deposit Md	Dec 23 1924

20-UNDERTAKER	ADDRESS
Wm Cook	502 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93210 CERTIFICATE OF DEATH.

90 D 93210

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Myrtle ST., 17 WARD)

2-FULL NAME Robert Powell

(a) RESIDENCE NO 400 Myrtle ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant None
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 23 1924 ROBERT R. KRAUTER Registrar
(Date) (Signature of Permit Clerk)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16 192X

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

(Signed) W K Grinnal, M. D.
(Coroner.)

12-22, 192 4 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ... mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health,

ADDRESS DEC 22 192

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93211 **CERTIFICATE OF DEATH.** 188-003 D 93211

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dont Know

(a) RESIDENCE No Dont Know ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	65	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) —
(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) —

14 Informant Son
(Address) —

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injured by Automobile
Accidental injuries
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Struck by Auto
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Grinnell, M. D.
(Coroner.)
12-12-, 192 4 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 12-22, 1924

20 UNDERTAKER — ADDRESS —

Commissioner Health,

Dec 2 1924 Robert R. Knauffmans Burial Permit Clerk

2071 — MORGUE.

Ref. Wm. H. Welch

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93212

CERTIFICATE OF DEATH.

51 D 93212

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 E. 28th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Zaccari

(a) RESIDENCE No. 1826 E. 28th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 3 1911

7 AGE: Years 13 Months 1 Days / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Rosario Zaccari

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Angelina Cicero

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Barbara Cicero

(Address): 1826 E 28th St

15 Filed DEC 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Dec 21, 1924

that I last saw him alive on Dec 21, 1924

and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Rheumatic Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DiStefano M.D.

Dec 22, 1924 (Address) 407 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 12/24/24

20 UNDERTAKER: Frank V. Lifestone — ADDRESS: 1800 E 31st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Eliza Savage

HEALTH DEPARTMENT—CITY OF [redacted]LTIMORE

D 93213

101-001 D 93213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 415 Orchard ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Savage

(a) RESIDENCE NO. 415 Orchard ST., WARD 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73		✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Anne Hill Balto. County Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos. Miller (Address) 415 Orchard Ave

15 Filed DEC 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18 1924, to Dec. 20th 1924, that I last saw h[redacted] alive on Dec. 20th 1924, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

From Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Grippe Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arthur Elliott, M. D.

Dec 24, 1924 (Address) 1st Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL DEC 23 1924

20 UNDERTAKER Samuel T. Hemsley

ADDRESS 578 N. Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93214

CERTIFICATE OF DEATH.

7-001

D 93214

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Sarah ave ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucretia Tobb

(a) RESIDENCE No 604 Sarah ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Entire yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colo	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER McKnew

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Cathrine Wilson
(Address) 604 Sarah ave

15 Filed ....., 192 ROBERT R. KRAUTER, Registrar
DEC 3 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or inquiry.~~ thereon and from the evidence obtained by said ~~Inquest, au-~~ ~~thority or inquiry.~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. About 1 mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) H. H. Jones M. D.
(Coroner.)

12-29, 192 (Address) 117 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL DEC 31 1924

20 UNDERTAKER Samuel D Hensley

ADDRESS 578 N Bond

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93215

CERTIFICATE OF DEATH.

D 93215
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Dropped dead on street
Division of Bakers
CITY OF BALTIMORE: (No. 1320 W. Lafayette ave ST., 16 WARD)

2-FULL NAME Charles M. Howard

(a) RESIDENCE No. 1320 W. Lafayette ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter D.S.H.
(b) General nature of industry, business, or establishment in which employed (or employer) Hutzler
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Moses Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella Johnson
(Address) 1326 W. Lafayette ave

15 Filed DEC 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) no history
(duration) yrs. mos. ds.

(Signed) J. T. Hennessy (Coroner.) M. D.
Dec. 22, 1924 (Address) 2802 Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec. 23 1924
20 UNDERTAKER	ADDRESS
Virginia E. Brooks	141 N. C

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

93216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93216

CERTIFICATE OF DEATH.

X164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Keyser ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alva Walker

(a) RESIDENCE NO. 2016 Keyser ST., WARD 8

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dan'l Inman

6 DATE OF BIRTH (month, day, and year): 1824

7 AGE: Years 100; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Drake's Branch Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mary Marshall 2016 Keyser st.

15 Filed DEC 23 1924 ROBERT R. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12 - 20 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec-17, 1924, to Dec. 20, 1924, that I last saw her alive on Dec. 20, 1924, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J A Walters M. D.

, 19 (Address) 1627 Ashland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Drake's Branch Va — DATE OF BURIAL: Dec 23 24

20 UNDERTAKER: Wm R. C. Elliott — ADDRESS: 1220 Ashland ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PREPARED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93217

CERTIFICATE OF DEATH.

D 93217

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1717 N Bradford St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie G. Smith.

(a) Residence No. 1717 N Bradford St., Ward .....
(Usual place of above) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles J Smith

6-DATE OF BIRTH (month, day and year) DEC 21 1890

7-AGE. 34 yrs. 0 mos. 1 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Va

PARENTS.

10-NAME OF FATHER, James Vaughn.

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Va.

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Va

11- (Informant) Charles J Smith

(Address) 1717 N Bradford St

15- 19.. Registrar.

DEC 29 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 22/24

17- I HEREBY CERTIFY, That I attended deceased from September 8 to December 22 19 24

that I last saw h.. Alive on December 22 19 24

and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) .... yrs. 4 mos. .... ds

CONTRIBUTORY (Secondary) .....

(Duration) .... yrs. .... mos. .... ds

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What ~~st~~ confirmed diagnosis? Clinical

12/ (Signed) Paul H. A. Meyer M. D

22, 19 24 (Address) 1031 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Wilson N. C.	12-23 1924
20-UNDERTAKER.	**ADDRESS**
Mrs Chas G Rohde	Arlington Ave

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93218

D 93218

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Cedar ST.: Westport WARD 25)

2-FULL NAME Marina V. Feeheley

(a) RESIDENCE. NO. 309 Cedar ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Feeheley

6 DATE OF BIRTH (month, day, and year) May 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER James Lapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Baltimore

12 MAIDEN NAME OF MOTHER Ella Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Baltimore

14 Informant Frank Snyder

(Address) 307 Patapsco St.

DEC 23 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924 to Dec 22 1924

that I last saw him alive on Dec 21 1924

and that death occurred, on the date stated above, at 5-30 A.m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Epheustian

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

Signed R. F. Campbell, M. D.

Dec 22, 1924 (Address) 1644 Harlwood

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk DATE OF BU 12-2

20 UNDERTAKER James Dignan & Son ADDRESS 1038 R

WARNING.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D93219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D93219

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1307 Lemmon (Fields) ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Juanita Norris

(a) RESIDENCE NO. 1307 Lemmon St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Norris

6 DATE OF BIRTH (month, day, and year): Dec. 20, 1888

7 AGE: Years 36; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md. Baltimore

PARENTS

10 NAME OF FATHER: John Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Martha Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Martha Fields

(Address) 1309 Lemmon St.

15 Filed DEC 23 1924, 19

ROBERT R. KRAUTH, Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-20-24 19

17

I HEREBY CERTIFY, That I attended deceased from 12-19-24 19 to 12-20-24 19,

that I last saw her alive on 12-20-24 19,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

Mitral Insufficiency

(duration) yrs. mos. 1 day ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) W. B. Butler M. D.

, 19 (Address) 2531 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Dec 24 1924

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 93220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-87 D 93220

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Seiling Sanatorium ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. Benson

(a) RESIDENCE NO. Seiling Sanatorium ST., WARD Laytonsville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Jane Benson

6 DATE OF BIRTH (month, day, and year): Aug 22, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: ? Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Mrs. Murphy

(Address): 1345 Poplar Grove St

DEC 23 1924 19 ROBERT R. KRADLER,

Burial Permit Clerk. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 23 19 24

17 I HEREBY CERTIFY, That I attended deceased from June 16, 19 20 to Dec 23, 19 24.

that I last saw him alive on December 20, 19 24,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 2411 Edmondson Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Paul V. Coolahan, M. D.

, 19 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laytonsville Md

DATE OF BURIAL: Dec 24 1924

20 UNDERTAKER: Roy W Barber Gaithersburg Md

ADDRESS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93221

CERTIFICATE OF DEATH.

74-001

D 93221

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Roland Ave ST., 27 WARD)

2-FULL NAME Louise Hobelmann

(a) RESIDENCE NO. 34 Roland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? 64 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1/45

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ..... W

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Germany
(State or country)

PARENTS

10 NAME OF FATHER John H. Hobelmann

11 BIRTHPLACE OF FATHER (city or town) ..... Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) ..... Germany
(State or country)

14 Informant Gilbert Wehr

(Address) 103 Hawthorne Road

15 Filed DEC 23 1924 ROBERT R. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1924, to December 22, 1924, that I last saw her alive on December 20, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) A. A. H. A. Meyer M. D.

Dec. 22, 1924. (Address) 2438 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	12/24 1924
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

MARGIN RESERVED FOR BINDING

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93222

CERTIFICATE OF DEATH.

101-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4813 Eastern ave No St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Vetter

(a) Residence No. 4813 Eastern ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) July 26, 1866

7-AGE. 58 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Martin Vetter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Caroline Siegmund

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Carrie Singstine

(Address) 4813 Eastern ave

13- Filed ..... 192.. Registrar.

DEC 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 16th 1924 to Dec 22 1924

that I last saw her alive on Dec 22nd 1924

and that death occurred, on the date stated above, at 3.25 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Jod M. D.

19 (Address) 4704 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL. Dec 26, 1924

20-UNDERTAKER. Zirkler & Zirkler — ADDRESS 1739 Eager

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D, 93223

HEALTH DEPARTMENT—CITY OF BALTIMORE

1617 901 ✓ D 93223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 W Baltimore St ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby O'Neill

(a) RESIDENCE NO. 2225 W Baltimore St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Dec. 22/24

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Harry ONeill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Raith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry ONeill (Address)

15 Filed DEC 23 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 19 24

17

I HEREBY CERTIFY, That I attended deceased from Dec.22 .1924 to Dec 22 .19 24

that I last saw him alive on Dec 22 .19 24

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cochran, M. D.

. 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	DEC 23 1924
20 UNDERTAKER	**ADDRESS**
Harry H. Wirtz & Co	1531 W. Lombard

Spec.—1-10-21—M&T—1500 Bks.

D 93224

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

D 93224

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) University Hospital ST., 22 WARD)

2-FULL NAME John P. Raymond

(a) RESIDENCE No. 307 Shaeffer ST., Druid Hill WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6 2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Friend's Inn

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Henry A. Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Delaney Fenhaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) University Hospital

15 Filed DEC 23 1924 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1924, to Dec. 22, 1924, that I last saw him alive on Dec 22, 1924, and that death occurred, on the date stated above, at 2 10 P m.

The CAUSE OF DEATH* was as follows:

(1) Cerebro-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F. Fox M. D.

, 19 (Address) Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 24 1924

20 UNDERTAKER H. E. Shugel — ADDRESS 424 N. Broadway

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93225

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hosp[illegible] ST. 2 WARD)

2-FULL NAME William Matusky

(a) RESIDENCE NO. 727 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Stated

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ayzik Matusky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rosie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed Robert P. Harrison, Registrar

DEC 23 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1924, to Dec. 23, 1924, that I last saw him alive on Dec. 23, 1924, and that death occurred, on the date stated above, at 7.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, laboratory

(Signed) J. F. Wheeler, M. D.

12-23-24 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, DATE OF BURIAL 12/24-1924.

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93226

CERTIFICATE OF DEATH.

118-097

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1633 N. Bradford St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Elizabeth Schnitzlein

(a) Residence No. 1633 N. Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 18 1923

7-AGE, ...yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Albert A Schnitzlein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Eva Jung

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Albert Schnitzlein

(Address) 1633 N. Bradford

15- Filed DEC 23 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/23/24

17- I HEREBY CERTIFY, That I attended deceased from December 21, 1924, to Dec 23, 1924, that I last saw h[illegible] alive on Dec 22, 1924, and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions & Rectal Haemorhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D F Herzog Md M. D.

Dec 23, 1924 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore — DATE OF BURIAL, Dec 24, 1924

20-UNDERTAKER, John Ulbrich — ADDRESS 2008 Calvert

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93227

CERTIFICATE OF DEATH.

D 93227

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 S Amm St. 2 Ward)

Registered No. 100

2-FULL NAME Henry Edward Mitchell

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 124 S Amm St, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced: (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) October 14 1924

7-AGE. ... yrs. 2 mos. 8 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: Peter Mitchell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Lena Cammarata

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14-Informant: Peter Mitchell

(Address): 124 S Amm St

15-Filed DEC 23 1924 Id: Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1924 to Dec. 22, 1924

that I last saw him alive on Dec. 22, 1924

and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Bronchial Pneumonia

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Contag.

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) Fred B. Smith M. D.

. 19 (Address) 11 E. Chase St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: Dec 24 1924

20-UNDERTAKER: Kendall Kilgus & Son — ADDRESS: 378 Amm

Spec.—1-10-21—M&T—1500 Bks.

D 93228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93228

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4006 Roland Ave ST., 13 WARD)

2-FULL NAME John B. Walter

(a) RESIDENCE NO. 4006 Roland Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER James Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Mrs. C. Jas Ensminger
(Address) 4206 Roland Ave

Filed DEC 23 1924 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1924, to Dec. 22, 1924, that I last saw him alive on Dec. 21, 1924, and that death occurred, on the date stated above, at 3 PM m. The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy, Chronic Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H Ruehl, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md

DATE OF BURIAL Dec 23 1924

20 UNDERTAKER M Rukert & Sons

ADDRESS 1827 W North Ave

P.S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

D 93229

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93229

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Louella Stewart

(a) RESIDENCE NO. 3228 Abell Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced, (write the word)~~
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Stewart

6 DATE OF BIRTH (month, day, and year) [illegible] 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer — —

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Husband - Harry Stewart (Address) 3228 Abell Ave ~~Garrison~~

15 Filed DEC 23 1924, 19 ROBERT P. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22nd 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 24th, 1924, to Dec. 22nd, 1924, that I last saw her alive on Dec. 22nd, 1924, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Metastatic Cancer Brain

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cancer cervix + rectum

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/11/24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. Thos. D. E. Seegar, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Va	Dec 24 1924
20 UNDERTAKER Robert Brookerson	ADDRESS Calhoun Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 955 Garrison av St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Howard B Shettle

(a) Residence No. 955 Garrison av St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Shettle.

6-DATE OF BIRTH (month, day and year) Aug 8/1883

7-AGE. 41 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Daniel Shettle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Ida Lander

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Ella Shettle

(Address) 955 Garrison av

15- 192 Registrar.

DEC 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-21-24

17- I HEREBY CERTIFY, That I attended deceased from December 3 1924 to December 21 1924

that I last saw him alive on December 21 1924

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cancer of the stomach

(Anemia)

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of March 1924

Was there an autopsy?

What test confirmed diagnosis Operation

(Signed) H. Young Wyethmeade M. D.

192 (Address) 4 Wyethmeade ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cemetery	Dec 24 1924
20-UNDERTAKER.	ADDRESS
Geo J. Ruth	1735 Edmondson ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93231

CERTIFICATE OF DEATH.

155

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 671 W. Barre ST.: 22 WARD)

2-FULL NAME William Yanchuk.

(a) RESIDENCE. No. 671 W. Barre ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 4 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1912.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Phillip Yanchuk.

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country) Russia

12 MAIDEN NAME OF MOTHER Natalea Jomala

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant William Yanchuk

(Address) 671 W. Barre St.

DEC 23 1924 . 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17 . 1924 . to Dec. 21 . 1924 . that I last saw h— alive on Dec. 21 . 1924 . and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

(1) acute osteomyelitis
(2) acute Suppurative arthritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia + Bronchs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Nov. 23 1924 + Dec. 13, 1924.

Was there an autopsy?

What test confirmed diagnosis? X-Ray + Lab. findings

(Signed) Chas S. Nesbitt . M. D.

. 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Dec 24 1924,
20 UNDERTAKER Charles B. Kuchaucka	ADDRESS 637 S Paca St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93232

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1526 Presstman ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M Werb

(a) RESIDENCE NO. 1826 Presstman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coach Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

050

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Werb

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Kind

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mrs Mary Yohnce (Address) 1826 Presstman

15 Filed ..... 192 ..... Registrar

EC 23 1924

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

(Signed) J. C. Kennedy, M. D.
(Coroner.)

Dec. 23, 1924 (Address) 2801 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	12/23 1924
20 UNDERTAKER Geo. A. Farley Jr.	ADDRESS Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93233

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Mount Hope Retreat St., 28th Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Hassig

(a) Residence No. Mount Hope Retreat St., 28th Ward Reading Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? Fourteen mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6-DATE OF BIRTH (month, day and year) May 18-1888

7-AGE: 36 yrs. 6 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Religious
(b) General nature of Industry, business, or establishment in which employed (or employer): Charity
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Heidelberg Baden Germany

PARENTS.
10-NAME OF FATHER: Ludwig Hassig
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Heidelberg Germany
12-MAIDEN NAME OF MOTHER: Johanna Granacher
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Heidelberg Germany

14-
(Informant): Records of Mt Hope
(Address): Baltimore Md

15-
Filed: Dec 23 1924
Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 22nd 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 16th 1924, to Dec 22nd 1924, that I last saw h.e. alive on Dec 21st 1924, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:
Cardiac Paralysis
Suddenly (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Mania Depressive Insanity (Duration) 3 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Reading Pa
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Frank J. Flannery M. D.
Dec 22nd 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Reading Pa — DATE OF BURIAL, Dec 23 1924

20-UNDERTAKER: STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 23 1924

Spec.—1-10-21—M&T—1500 Bks.

1878 D 93234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓ D 93234

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 18 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tilghman

(a) RESIDENCE NO. 460 Union St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Tilghman

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Mazie Williams

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1924, to Dec 22, 1924, that I last saw h~~im~~ alive on Dec 22, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Otitis media
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? In hosp

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edmund H. Kerfoot, M. D.

12/23, 192X (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Auburn Cem DATE OF BURIAL Dec 24 24

20 UNDERTAKER Samuel Hawley ADDRESS 725 N Calhoun

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93235

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 N Amity St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Wm Earl

(a) Residence No. 14 N Amity St.,..... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown.

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bartender

(b) General nature of industry, business, or establishment in which employed (or employer) 044

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Unknown

14- (Informant) Mary Smith

(Address) 12 N Amity St.

15- Filed DEC 24 1924, ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 22/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 5, 19 24, to Dec 22, 19 24,

that I last saw h alive on Dec 22, 19 24,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? J Norwood

(Signed) M. D.

Dec 26, 19 24 (Address) 929 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loud Auburn Cemetery | DATE OF BURIAL, Dec 26 19 24

20-UNDERTAKER, Mrs Ida Snader | ADDRESS 1725 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93236

CERTIFICATE OF DEATH.

46 D 93236

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 425 N. Eden St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bantum

(a) Residence No. 425 N. Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) 1866

7-AGE. 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Evangelist

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. R. A. Elliott

(Address) 1725 Ashland Ave.

15- DEC 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1924 to Dec 23 1924 that I last saw h alive on Dec 22 1924 and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestines

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? See Path. Report

(Signed) J. Edward Fisher M. D.

12-23 1924 (Address) 1612 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec 28 1924

20-UNDERTAKER, Mrs R. A. Elliott — ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93237

CERTIFICATE OF DEATH.

31 D 93237

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 N Bond ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Barnes

(a) RESIDENCE. No. 605 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Single.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs R. G. Elliott

(Address) 1725 Ashland Ave

15 Filed DEC 24 1924 19 ROBERT R. KRAETER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1924, to Dec 22, 1924.

that I last saw h— alive on Dec 22, 1924.

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

about 3
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Cary Burns M. D.

12-24-24 19 (Address) 2057 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 24 1924

20 UNDERTAKER Mrs R. G. Elliott ADDRESS 1725 Ashland Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A

Spec—12-23-24—E.B.R.S.—400 Bks.

93238

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 93238

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Hawthorne Road Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara M. Becker

(a) Residence No. 412 Hawthorne Road Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Becker

6-DATE OF BIRTH (month, day and year) June 2. 1847

7-AGE. 77 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Julius C. Muller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eliza Metz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Ernest J. Becker

(Address) 220 W. Lanvale St.

15- ROBERT R. KRAUTER

Filed..... 1924 Burial Permit Issued.....

DEC 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 23/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 16th 1924 to Dec 23rd 1924

that I last saw h[illegible] alive on Dec 22nd 1924.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Eugene Langloe M. D.

, 19 (Address) 830 W. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 24... 1924

20-UNDERTAKER. John O. Mitchell ADDRESS 120 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAVID WIESENBERGER.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1970 93239 — X 90 D 93239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... Wiesenberger ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dave Wiesenberger

(a) RESIDENCE NO. New York city N. Y. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 66 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa Wiesenberger

6 DATE OF BIRTH (month, day, and year) Aug. 17 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Henry Wiesenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Rachael ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 24 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 - 1924, to Dec 22 - 1924, that I last saw him alive on Dec 22 - 1924, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? New York City
Did an operation precede death? yes Date of Dec 22 24
Was there an autopsy? yes
What test confirmed diagnosis? autopsy

(Signed) Robert Wheeler, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooklyn, N. Y.	12/29/1924
20 UNDERTAKER David Sondheim	ADDRESS 115 & W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93240

CERTIFICATE OF DEATH.

57

D 93240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 251 Maryland Ave ST.; Westfall 25 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth B. Green

(Residence in Baltimore: No. 251 Maryland Ave St.; 18 yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Jan (Month) 14 (Day) 1859 (Year)

7-AGE, 65 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Penn

PARENTS.

10-NAME OF FATHER, Henry Arnold

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Elizabeth Frederick

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
William Green (Informant)
251 Maryland Ave (Address)

15- Filed DEC 24 1924 ROBERT B. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1924, to Dec. 22 1924, that I saw h ed alive on Dec 21 1924, and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Pancreas

(Duration) yrs. mos. ds.

(Signed) Wm E. Green M. D.

, 191... (Address) 1636 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec. 26., 1924

20-UNDERTAKER John J. Fields ADDRESS 1300 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-04

D 93241

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1620 N Bruce ST.: 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Son of Olivia West and Henry Morgan

(a) RESIDENCE. NO. 1620 N Bruce ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fortina 6½ Months

6 DATE OF BIRTH (month, day, and year) Dec 20, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 1620 N Bruce
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Morgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Martins Co. Va

12 MAIDEN NAME OF MOTHER Olivia West

13 BIRTHPLACE OF MOTHER (city or town) Flowers Co
(State or country) Va

14 Informant Olivia West
(Address) 1620 Bruce St

15 Filed ..... 19 .....

DEC 24 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1924 to Dec 22, 1924, that I last saw h[illegible] alive on Dec 22, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility 6 hrs
Marasmus 6½ Months

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal

(Signed) Wm A Westcott, M. D.

Dec 23, 1924 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Dec 24 1924
20 UNDERTAKER Mrs Jas. H. Dennis	ADDRESS 1363 Pulaski St
Rev T. E. Nelson	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93242

128

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 N. Mount ST. 16 WARD)

2-FULL NAME Mrs. Daisy Jane Brown

(a) RESIDENCE NO. 1040 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Md 1913

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman Brown

6 DATE OF BIRTH (month, day, and year) March 5th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Stokes Va.

PARENTS

10 NAME OF FATHER Simmons Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stokes Va

12 MAIDEN NAME OF MOTHER Belle Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stokes Va

14 Informant Nevada Brown (Address) 1624 Chapel St.

15 DEC 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13th, 1924, to Dec. 21st, 1924, that I last saw h[illegible] alive on Dec 21st, 1924, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) R. E. Bell, M.D.

, 19 (Address) 1214 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 24 1924

20 UNDERTAKER Mrs Jas. H. Dennis

ADDRESS 1303 Pressman St

per T. E. Kelson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93243

CERTIFICATE OF DEATH.

129D 93243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 Chester ST.) 20 WARD)

2-FULL NAME Abraham Cohen

(a) RESIDENCE NO. 2017 Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of Bessie Cohen

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Nachun Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dorthun

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): H. Shelton 415 Pulaski

15 Filed DEC 24 1924 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1924, to Dec 23 1924, that I last saw h. m. alive on Dec 23 1924, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation 1 hr.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Cohen M. D.

19 19 (Address) 1417 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodph Road	12/24 1924
20 UNDERTAKER	ADDRESS
Jack Levis	1439 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93244

CERTIFICATE OF DEATH.

49 D 93244

1-PLACE OF DEATH 400 E Balto
Registered No.

City of BALTIMORE: (No. Hebrew Imeurable Home St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philipp Blindell

(a) Residence No. 134 S. Eden Road St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lena Blinder

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
32 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Russia

PARENTS.
10-NAME OF FATHER Louis Blinder
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12-MAIDEN NAME OF MOTHER Rachael
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

11- (Informant) Lena
(Address) 1434 E Balto

13- DEC 24 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1924, to Dec 23 1924, that I last saw h. alive on Dec 23 1924, and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Contusions of throat

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D
, 19 (Address) 18 S Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodmen Circle Pet Cem	12-27 1924
20-UNDERTAKER.	ADDRESS.
per Lena	1439 E Balto

N. B.—WHITE PENCIL WRITING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93245

CERTIFICATE OF DEATH.

49

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 528 South Broadway St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Rickes

(a) Residence No..... 528 South Broadway St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of ~~FFFFFFF~~ Sallie A. Hollingsworth

6-DATE OF BIRTH (month, day and year) Feb. 28, 1850

7-AGE: 74 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Druggist

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER, John Rickes

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Kestner

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. Sallie A. Rickes
(Address) 528 South Broadway

15- Filed..... 19.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

DEC 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 22/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1924, to Dec 22d, 1924, that I last saw h.. alive on Dec 22d, 1924, and that death occurred, on the date stated above, at 1330 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Gruning M. D.

Dec 22, 1924 (Address) 1908 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 12/24, 19 24

20-UNDERTAKER: Henry W. Spears & Son — ADDRESS: 805 E. Calvert

N. B.—WHOLE number of years should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93246

CERTIFICATE OF DEATH.

43 ✓

REGISTERED NO. D 93246

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2620 Keyser ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Pollock

(a) RESIDENCE NO. 2620 Keyser ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie R. Pollock

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driller at

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Dock Co 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn

PARENTS

10 NAME OF FATHER Hugh A. Pollock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Sadie R. Pollock

(Address) 2620 Keyser St

Filed DEC 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1 1924 to Dec 23 1924

that I last saw him alive on Dec 21 1924

and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Palate

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Rumbock M.D.

122 1924 (Address) 1501 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 26 1924
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1201 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1765 D 93247

CERTIFICATE OF DEATH.

31 D 93247

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kline

(a) RESIDENCE NO. 136 N. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	14	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Drusilla Trail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address)

Filed DEC 24 1924

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21- 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 - 1924, to Dec 21, 1924.

that I last saw him alive on Dec 21 - 1924

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos.? ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 35 ds.?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray - Spinal fluid examination tuberculin test

(Signed) Edmund W. Kemper, M. D.

12/21, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fremont Cemetery — DATE OF BURIAL Dec. 24, 1924

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION MUST BE STATED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-28—M&T—100 Bks.

D 93248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93248

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Brevard ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Green

(a) RESIDENCE No. 902 Brevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lovell Green

6 DATE OF BIRTH (month, day, and year) 12/ 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Saml Swann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas L Green
(Address) 902 Brevard St

15 Filed ....., 192.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Dec. 22 192 4 (Address) 2 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	12/30 192 4

20 UNDERTAKER Saml T Kennedy ADDRESS 578 Mt Idale

mation should be carefully supplied. AGE should be stated EXACTLY. If under 1 year, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93249

Registered No. 90

1-PLACE OF DEATH St. Joseph's Hosp. 6

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Cronin

(a) Residence No. 2508 Fayette St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick M Cronin

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE About 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Mrs Mary E Roth

(Address) 2508 E Fayette St

15- Filed ..... 192..... ROBERT R. KRAUSE Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924 to Dec 23, 1924

that I last saw h. alive on Dec 23, 1924

and that death occurred, on the date stated above, at 1.04 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Endocarditis

(Duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. B. Sybert, M. D

, 19 (Address) St. Jos. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Dec 26 1924
St Patricks Cem	
20-UNDERTAKER, Wm Cook	ADDRESS 502 E Lock Lane

N. B.—ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93250

CERTIFICATE OF DEATH.

90 D 93250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2111 East Chase ST., 8 WARD)

2-FULL NAME William H. Gordon

(a) RESIDENCE NO. 2111 East Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Gordon

6 DATE OF BIRTH (month, day, and year) 04-12

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer E. J. Morgan

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Finley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Cora M. Gordon

(Address) 2111 E. Chase

15 Filed DEC 24 1924, 19 ROBERT R. KRAMER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1924 to Dec 23 1924.

that I last saw him alive on Dec 21 1924

and that death occurred, on the date stated above, at 2 45 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(duration) yrs. mos. 1 mo.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Albert H. Levy, M. D.

12/27/24 Address 1502 E. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 12/26 1924

20 UNDERTAKER William Cook

ADDRESS 502 E. Lex St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93251

CERTIFICATE OF DEATH.

D 93251

REGISTERED NO. C 15 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Pressman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hann

(Residence in Baltimore: No. 3038 Pressman St. St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec (Month) 21 (Day), 1924 (Year)

7-AGE, ...yrs.....mos.....da. If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... No
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Jos. R. Hann

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mae Purcell

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. D. Draught

(Address) #16 now 2 Preston St.

15-

Filed DEC 24 1924 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 21 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1924, to Dec 21 1924, that I saw him alive on Dec 21 1924, and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

5 minutes
(Duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) (Foetus is 6 months)

.... (Duration) ....yrs....mos....da.

(Signed) Wm. D. Draught M. D.

(Address) 16 E. Preston St.

Dec 21, 1924

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Dec. 24, 1924

20-UNDERTAKER T. A. Frazier & Son ADDRESS 703 Hanover St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Freedman St.; 15 WARD)

2-FULL NAME William Charles Baby Haim

(Residence in Baltimore: No. 3038 Freedman St.; ...yrs.,...mos.....ds.)

REGISTERED No. C 161-B 93252

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 21, 1924
(Month) (Day) (Year)

7-AGE, ...yrs...mos. 2½ ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jos C. Haim

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER MacCurcell

13-BIRTHPLACE OF MOTHER (State or Country), Plymouth Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. R. Draught

(Address) # 16 E Preston St.

15-

Filed....., 191.... Registrar.

DEC 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1924, to Dec 23 1924, that I saw h[illegible] alive on Dec 22 1924, and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Exposure at Prematurity (Six Months)
Boston

(Duration) ...yrs. ...mos. 2½ ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Wm. R. Draughty M. D.

12/23, 1924 (Address) # 16 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem — DATE OF BURIAL, Dec. 24.., 1924

20-UNDERTAKER F. A. Krause & Son — ADDRESS 703 Hanover St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93253

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bull

(a) RESIDENCE No. Bay View asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Manuel-Bull

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 12-24-1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-8, 1924, to 12-22 1924, that I last saw him alive on 12-22, 1924 and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 2 mos. (History) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sx.

(Signed) Claude A. Hance M. D.

12-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

DEC 24 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK—
mation, should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

394 12-24-1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93254 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1012 Granby st St., 3 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Wolf Kravitz

(a) Residence No. 1012 Granby St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie

6-DATE OF BIRTH (month, day and year): [illegible] 1859

7-AGE: 65 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.
10-NAME OF FATHER: Sol Kravitz
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia
12-MAIDEN NAME OF MOTHER: Mprower
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-(Informant): Mrs. Kravitz
(Address) 1012 Granby St

15-Filed DEC 27 1924, 19?
Robert F. Garrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 24/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1924, to Dec. 23, 1924, that I last saw him alive on Dec. 23, 1924, and that death occurred, on the date stated above, at 3:59 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease.

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Herman Seidel, M. D.
12/24, 1924 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL, 12/24, 1924

20-UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.F.S.—400 Blks.

D 93255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

Registered No.

2-FULL NAME Mr Isaac Mohilner

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 461 N.W. 5th St. Miami Florida St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6-DATE OF BIRTH (month, day and year) About [illegible]

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rabbi

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Do not know " "

14- (Informant) Mr. Isaac Mohilner

(Address) 461 - N.W. 5th St. Miami Florida

15- [illegible]

16- [illegible]

EC 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/23/24

17- I HEREBY CERTIFY, That I attended deceased from 12-10-24 19 to 12-23 19 24

that I last saw h[illegible] alive on 12-23 19 24.

and that death occurred, on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastric Tumor

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? In Florida

Did an operation precede death? Yes Date of? 2

Was there an autopsy? No not done here

What test confirmed diagnosis? Examination

(Signed) I. Clauner Cohn M. D

12/23, 19 24 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Miami Florida — DATE OF BURIAL: 12/24 19 24

20-UNDERTAKER, Sol Levinson & Bro — ADDRESS 1121 E Dade St

should be carefully supplied. AGE should be stated EXACTLY. PERSONAL AND STATISTICAL PARTICULARS are very important. Please see instructions on back of certificates. Exact statement of OCCUPATION is very important. Please see in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D 93256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93256

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 Fleet St. ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ray Simon

(a) RESIDENCE No. 3201 Fleet St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	17	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Fred Simon

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Shorty

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant Amelia Ott (Address) 3201 Fleet St.

15 Filed Dec 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1924 to December 22, 1924 that I last saw him alive on December 22, 1924 and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Dislocation of Heart.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Valvular Lesion of Heart (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Valentine M. D. M. D.

Dec 24. 1924 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Lutheran Cemetery DATE OF BURIAL Dec. 25 1924

20 UNDERTAKER Fredk Lassahn & Sons ADDRESS Fullerton

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 24 1924

Spec.—1-10-21—M&T—1500 Blks.

D 93257 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D 93257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 141 N. Chapel ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Hatcher

(a) RESIDENCE NO. 141 N. Chapel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nil.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: James Hatcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Lettie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: James Hatcher (Address) 141 N. Chapel St

15 Filed DEC 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 23/12/1924

17 I HEREBY CERTIFY, That I attended deceased from 22/12/, 1924, to ....., 19..., that I last saw him alive on 22/12/, 1924, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
about a week

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbuncle of back

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of? —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) E. Mayfield Boyle, M. D.

(Address) 480 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery

DATE OF BURIAL: Dec 25: 1924

20 UNDERTAKER: Edward Bryan

ADDRESS 1681 Orleans st

N. B.—WRITE LEGIBLY. Physicians and undertakers are requested to see that every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 93258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

100 D 93258

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Myrtle Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancie Helen Jackson

(a) RESIDENCE NO. 1037 Myrtle Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 24 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
—	✓	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Ny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Jackson (Address) 1037 Greenville Ave

15 Oct 24 1924 Robert P. Garrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24th, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1924, to Oct 22, 1924, that I last saw her alive on Oct 21 1924, and that death occurred, on the date stated above, at 7:55 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. ✓ mos. 24 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No Findings

What test confirmed diagnosis? Clinical

(Signed) F. Fee Ellis, M. D.

Oct. 24 1924 (Address) 624 Woodbourne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-27-24
20 UNDERTAKER David Carlon	ADDRESS Pratt

NB.—WRITE PLAINLY. PHYSICIANS ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93259

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Southern Hospital ST., 15 WARD

2-FULL NAME M. Elizabeth Hemmick

(a) RESIDENCE NO. 2403 Garrison Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County
(State or country) Md

PARENTS

10 NAME OF FATHER George Hemmuck

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann Shipley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant J. C. Smith
(Address) 2403 Garrison Ave

15 Filed 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

C 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1924 to 12-23 1924

that I last saw her alive on 12-23 1924

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) senility & cystitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Henry Shipley M. D.

12-23 1924 (Address) 5102 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 26 1924
20 UNDERTAKER	ADDRESS 1532
George J Smith	Hollins St

N. B.—WHITE PENCIL should be stated EXACTLY. FIGURES should be written. AGE should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be written. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93260

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001 D 93260

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 Callender ST., 18 WARD)

2-FULL NAME Emma Pearson,

(a) RESIDENCE NO. 136 Callender St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~ yrs. ~ mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White,

5 Single, Married, Widowed, or Divorced, (write the word): Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single,

6 DATE OF BIRTH (month, day, and year): Dec. 14, 1924

7 AGE: Years ~ Months ~ Days 10 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None,

(b) General nature of Industry, business, or establishment in which employed (or employer): None,

(c) Name of employer: None,

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Abraham Pearson,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md,

12 MAIDEN NAME OF MOTHER: Ella Thompson,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Ella Pearson, (Address) 136 Callender St.

15 Filed ... 19... ROBERT F. MATTSON, Registrar

Burial Permit Clerk.

DEC 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec, 20, 1924, to Dec, 24, 1924,

that I last saw her alive on Dec. 24, 1924,

and that death occurred, on the date stated above, at 10 30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(duration) ~ yrs. ~ mos 4 ds.

CONTRIBUTORY (Secondary): None,

(duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. Chas. Barton, M. D.

12/24, 1924 (Address) 888 N. Lemmond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Dec 24, 1924

20 UNDERTAKER: Cowan & Son, per E. J. Cowan

ADDRESS: Portsdale Md

N.B.—WRITE PLAINLY. ALL information should be carefully supplied. AGE, PLACE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93261 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93261

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 400 N. Fulton Ave St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. J. A. Kirk Coles

(a) Residence No. Home for the aged of the M. E. Church St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 20, 1847

7-AGE	If LESS than 1 day
77 yrs. 8 mos. 4 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS

10-NAME OF FATHER, William Coles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Mary Kirk

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), md

14- (Informant) E. Starbuck

(Address) 400 N. Fulton Ave

15- Filed DEC 24 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 24/24

17- I HEREBY CERTIFY, That I attended deceased from Jany 7 1924 to Dec 24 1924

that I last saw him alive on Dec 22 1924

and that death occurred, on the date stated above, at 2. a m.

The CAUSE OF DEATH* was as follows:

Hepatitis Chronic

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(Duration) ✓ yrs. 11 mos. — ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) George L Shannon M. D

12/24, 1924 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem	Dec 26, 1924
20-UNDERTAKER	ADDRESS
George J Smith	1532 Hollins st

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93262

CERTIFICATE OF DEATH.

7 + 47

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Virginia Otterbourg

(a) Residence No... Johns Hopkins Hospital St., Ward Salisbury N.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? 32 yrs. 5 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Marion Otterbourg

6-DATE OF BIRTH (month, day and year) June-27-1892

7-AGE, 32 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)... none

(c) Name of employer... none

9-BIRTHPLACE (city or town) (State or Country), OOLTEWAH TENN.

PARENTS.

10-NAME OF FATHER, Isaac Wolfe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), OOLTEWAH TENN.

12-MAIDEN NAME OF MOTHER, Callie Starrs.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Cleveland. TENN.

14- (Informant) Mr. Marion G. Otterbourg (husband)

(Address) OOLTEWAH - TENN.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

C 24 1824 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 24/24.

17- I HEREBY CERTIFY, That I attended deceased from Dec 10, 19.24, to Dec 23, 19.24

that I last saw her alive on Dec 23, 19.24.

and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows:

Carcinoma of rt. breast with extensive metastasis to liver & probably lungs.

(Duration) ....yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Liver involvement (Duration) ....yrs. 3 mos. ....ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Dec 16, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic section

(Signed) Thos Harrold M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. OOLTEWAH, TENN. DATE OF BURIAL, Dec-24- 19.24.

20-UNDERTAKER. Stewart & Mowen Co. ADDRESS 108 W North Ave.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93263

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5855 Penn R.R. Office ST., Foot of Hanover St. WARD 10)

2-FULL NAME John H. Kyler

(a) RESIDENCE No 1103 Gilmor St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kyler

6 DATE OF BIRTH (month, day, and year) Dec 3 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 074

(b) General nature of industry, business, or establishment in which employed (or employer) Coal passer

(c) Name of employer Calvert Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nathaniel Kyler

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md

12 MAIDEN NAME OF MOTHER Virgil J Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Kyler (Address) 1103 Gilmor St

15 Filed DEC 25 1924 192 ROBERT F. KRAUSE, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(a) ..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Complications

(duration) yrs. mos. ds.

(Signed) G E Bleed M. D.

(Coroner.)

12/24/24, 192 (Address) 1 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Dec 29 1924
20 UNDERTAKER Samuel H Grumley	ADDRESS 1 E Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly coded.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93264

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Somerset ST., 5 WARD)

2-FULL NAME Hugh Cephard

(a) RESIDENCE NO. 519 Somerset ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catharine Cephard

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Saml Cephard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs R. A. Elliott (undertaker) 1725 Ashland Ave.

15 Filed DEC 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1924, to Dec 21 1924, that I last saw him alive on Dec 20, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

12/24 1924 (Address) 114 City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashley Cemetery — DATE OF BURIAL Dec 25 1924

20 UNDERTAKER Mrs R. A. Elliott — ADDRESS 1725 Ashland

N. B.—WRITE LEGIBLY. Information should be carefully supplied. AGE should be stated EXACTLY. Physicians should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93265

CERTIFICATE OF DEATH.

1825 D 93265

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital St., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Muldykau

(a) RESIDENCE NO. 1028 Biddle St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE: Years 61 | Months — | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) 062
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Easton Md

10 NAME OF FATHER: Albert Muldykau

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 NAME OF MOTHER: Mrs. Mitchell Wickham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

PARENTS

14 Informant: M. Spence (Address): Easton Md

15 Filed ... 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

DEC 25 1925

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Acc Fall.
Fracture of Skull.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.
(Signed) H. E. Slade, M. D.
(Coroner.)
Dec 24 192 (Address) 1456 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md — DATE OF BURIAL: 12-25-25

20 UNDERTAKER: David Easton — ADDRESS: Ea an

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact duration of each condition is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93266

CERTIFICATE OF DEATH.

D 93266

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1404 Carrish St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Oliver

(a) Residence No. 1404 Parish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, (White, Black, Mulatto, or Chinese (Write the word.)) Colored

5-If married, widowed, or divorced Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1883

7-AGE. 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto City

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Unknown

14- (Informant) Walter Green

(Address) 1404 Carrish St.

15- Filed DEC 25 1924 ROBERT R. [illegible] Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-23-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 19xx to Dec 23 19xx

that I last saw h[illegible] alive on Dec 23 19xx

and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(Duration) 0 yrs. 1 mos. [illegible] ds.

CONTRIBUTORY (Secondary) Hardening of arteries

Nephritis (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) B. N. Haletsen M. D.

Dec 24 192x (Address) 12 W Penn Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12-26-24
20-UNDERTAKER Dennis Forbes	ADDRESS 916 Eutaw

should be carefully supplied. AGE should be accurately stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93267

D 93267

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4507 Liberty Heights ST. 28 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Caroline Gilbert

(a) RESIDENCE NO. 4507 Liberty Heights Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Aquilla Gilbert

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Fowler

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Miss Bessie E. Gilbert
(Address) 4507 Liberty Hts. Ave.

15 Filed DEC 25 1924 ROBERT R. KNAPP Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1924, to Dec. 23, 1924, that I last saw her alive on Dec. 23, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

debility from age and a broken hip which occurred Dec. 2, caused by a fall in bathroom.

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No examination

What test confirmed diagnosis? symptoms and physical

(Signed) J. F. Shemwell, M. D.

Dec. 24 1924 (Address) 2216 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Dec 26 1924

20 UNDERTAKER Peter Stoltz ADDRESS 1237 Pennsylvania Ave

N. B.—WHITE PAPER, BLACK INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93268

CERTIFICATE OF DEATH.

D 93268

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2123 E. Fairmount Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Bessie Shochet

(a) Residence No. 2123 E. Fairmount Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 4 mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Bennie Shochet

6-DATE OF BIRTH (month, day and year)

7-AGE. 28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hsw

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Abraham Bos

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Shera

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Bennie Shochet

(Address) Peterson Md

15- Filed 12 2 1924 Registrar.

D 12 5 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/24/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1924 to Dec. 24 1924

that I last saw h. alive on Dec. 24 1924

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

Mitral stenosis & insufficiency

Cause unknown

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. F. Rus per F. A. Rus M. D.

12/25, 1924 (Address) 24 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Veteran Woodlawn

DATE OF BURIAL. 12/27/24

20-UNDERTAKER. Jack Levin

ADDRESS 1439 E. Baltimore St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93269

CERTIFICATE OF DEATH.

10-90 ✓ 93269

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Matthews

(~~Residence in Baltimore.~~ No. Aberdeen, Harford Co., Md St.; .....yrs., ...mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	Black	Mard.

6-DATE OF BIRTH, Dec. 31st, 1859
(Month) (Day) (Year)

7-AGE, 64 yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Columbia S.C.

PARENTS.

10-NAME OF FATHER. Pumphrey Matthews

11-BIRTHPLACE OF FATHER (State or Country), S.C

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Matthews

(Address) Aberdeen Md.

15- DEC 26 1924 Filed....., 191..... ROBERT R. KRAUTER, Deputy Health Officer. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 24, (Day) 1924. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec-19-1924, to Dec-24-1924, that I saw him alive on Dec 24-1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) W. J. Parr M. D.

12/26/24, 191... (Address) Franklin Sq. Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 6 ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Aberdeen Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Aberdeen Md	Dec. 25, 1924.
20-UNDERTAKER	ADDRESS
Wm. J. Pickens & Sons	Bulle

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 93270

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wolf Goldenberg

(a) RESIDENCE NO. 17 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dora Goldenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaning

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Goldenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-25, 1924, to 12-25, 1924,

that I last saw him alive on 12-25, 1924,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hem. Hemiplegia Mitral Stenosis, Chr. Nephritis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Leigh D. Frey, M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakeview Rosedale — DATE OF BURIAL 12/25 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto

N. B.—WHITE PAPER. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93271

148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Nelson

(a) RESIDENCE NO. 211 N. Pine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred .5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	black	married

5a If married, widowed, or divorced (or) WIFE of Daniel Nelson

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Rose Belton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Sarah Nelson

(Address) 211 Pine St.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-21, 1924, to 12-22, 1924, that I last saw h[illegible] alive on 12-22, 1924, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(antepartum + postpartum)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-22-24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Morey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden S C

DATE OF BURIAL 12/25/24

20 UNDERTAKER R L Gross 1405 Mcelderry St

ADDRESS

...E should be stated EXACTLY. Abbreviations ... mation should be carefully supplied. AGE sh... CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on ba... it may be properly classified. Exact statement of OCCUPA- on back of certificates.

...AFE...

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93272 ✓ × 89 D 93272

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH 4 E Con.

CITY OF BALTIMORE, (No. St Paul & Madison ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Seder

(a) RESIDENCE NO. St Paul & Madison St ST., WARD Chicago Ill.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Seder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Fleisman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mr Seder
(Address) East Liberty Pa

15 Filed DEC 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1924.

17 I HEREBY CERTIFY, That I attended deceased from December 8, 1924, to December 25, 1924.

that I last saw him alive on December 25, 1924

and that death occurred, on the date stated above, at 11 20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma pertonei

(duration) about 2 yrs. mos da.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Pittsburg

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Henry T. Thomas Jr. M. D.

, 19 (Address) 128 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Liberty Pa	Dec 25 1924
20 UNDERTAKER Henry W. Jenkins & Co	ADDRESS Pittsburgh Pa

ROBERT R. MONTER
Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. Punctuation
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificates.

OAKLAND

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93273

CERTIFICATE OF DEATH.

6 + 124D 93273

Registered No.....

1-PLACE OF DEATH Church Home and Infirmary

City of BALTIMORE: (No. RANDOLPH St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sydney Peery

(a) Residence No. Winchester Va St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Nov 3-1902

7-AGE. 22 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Book Keeper.

(b) General nature of Industry, business, or establishment in which employed (or employer) Lumber 008

(c) Name of employer Schmelz Rosenberger Co

9-BIRTHPLACE (city or town) Stephen City Va.
(State or Country)

PARENTS.

10-NAME OF FATHER. Lloyd Randolph Peery

11-BIRTHPLACE OF FATHER (city or town) Stephen City Va.
(State or Country).

12-MAIDEN NAME OF MOTHER, Helena V. McLeod.

13-BIRTHPLACE OF MOTHER (city or town) Stephen City Va
(State or Country).

14- (Informant) Margaret McCleary

(Address) Winchester Va

15- Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-25-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1924 to Dec 25 1924

that I last saw him alive on Dec 25 1924

and that death occurred, on the date stated above, at 4.44 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver, multiple
Septicaemia - streptococcus

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis, general

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home explosion 4 to 7 days before liver abscess

Did an operation precede death? Yes Date of Dec 19, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation, blood culture, clinical findings

(Signed) Henry U.P. Wilson Jr M.D. M. D.

19 (Address) Grant House Va

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Winchester Va. DATE OF BURIAL, Dec 28 1924

20-UNDERTAKER. H E Wright ADDRESS 444 W Boscawen

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93274

CERTIFICATE OF DEATH.

88-003 D 93274

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE. (No. Union Memorial Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Sivers

(Residence in Baltimore: No. 823 Belgian Ave St. (yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. July 3 1846
(Month) (Day) (Year)

7-AGE. 78 yrs. 5 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Maryland

PARENTS:

10-NAME OF FATHER. Joseph H. Sivers

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Shirley

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Joseph Jacobs

(Address) 823 Belgian Ave

15-

Filed ....., 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 23 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Automobile accident

Injuries Pending.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Lonsdale M. D.
Coroner.

Dec 25 192 (Address) 3632 Roland Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount — DATE OF BURIAL. Dec 27 1924

20-UNDERTAKER. William Cook — ADDRESS 502 E Nath

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly certificate. See instructions on back of certificate is very important.

Cor. 8-12-24—M.S.—100 Bks.

D 93275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93275

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos Pinkney

(a) RESIDENCE NO. Relay Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1905

7 AGE — Years: 19 — Months: 7 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Emma Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Arabia Md.

14 Informant: John Pinkney
(Address): Relay Maryland

15 Filed ..... 192 .....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, Autopsy or Inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) yrs. 5 hrs mos ds.

CONTRIBUTORY (Secondary) Struck by B&O Train

(duration) yrs. 5 mos. ds.

(Signed) H K Freeman, M. D.
(Coroner.)

12-25, 1924 (Address) 117 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn.

DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER: Wm Cook.

ADDRESS 602 E North.

CAUSE OF DEATH is very important. See instructions on back of certificate.

93276

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

16 D 93276

REGISTERED NO. C .....

1 PLACE OF DEATH Belvina Ave & Belvidere, (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Edgewood & Sanitarium WARD)

2 FULL NAME Elizabeth B Wagner

(Residence in Baltimore: No. Edgewood Sanitorium St.: 60 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: about (Month) (Day), 1836 (Year)

7 AGE: about 88 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Pa.

PARENTS

10 NAME OF FATHER: William Wagner

11 BIRTHPLACE OF FATHER (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Rosana Fishpaw

13 BIRTHPLACE OF MOTHER (State or country): Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J H Randall

(Address) 13 East 22d.

15 DEC 26 1924 ROBERT J. KRAUTER, Burial Permit Clerk

Filed ..... 19.. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 24 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Dec 24 1924

that I saw her alive on Dec 24, 1924

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Septicemia of Age

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. H. Randall M. D.

Dec 26, 1924 (Address) 13 East 22d St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. 8 mos. ds. In the State yrs. all life mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Drummond

DATE OF BURIAL: Dec 26, 1924

20 UNDERTAKER: W M Cook

ADDRESS: 502 E Fayette

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93277

CERTIFICATE OF DEATH.

D 93277

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. St. Joseph's Hosp. Gilbert St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H. Lutz

(a) Residence No. 1314 N. Caroline St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary M. Lutz

6-DATE OF BIRTH (month, day and year) Dec. 9, 1863

7-AGE. 11 yrs. mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bank Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Trust Co
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto, Md

PARENTS:
10-NAME OF FATHER, Nicholas Lutz
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md
12-MAIDEN NAME OF MOTHER, Mary Lutz
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mary Lutz
(Address) 1314 N. Caroline St

15- Filed DEC 26 1924 192 ROBERT R. KRAUTER, Burial Permit Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-24-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1924 to Dec 24 1924, that I last saw h, m alive on Dec 24 1924, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
Pulmonary Oedema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. R. femur
Arteriosclerosis (Duration) hypertension yrs. mos.

18-Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Evidence - x-ray

(Signed) Geo. B. Gilbert M D
19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. 12/28/ 1924

20-UNDERTAKER, Wm. Cook — ADDRESS 5072 Belair Ave

should be carefully supplied. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93278

CERTIFICATE OF DEATH.

D 93278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2021 Ashland Ave ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Appell

(a) RESIDENCE NO. 2021 Ashland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Appell.

6 DATE OF BIRTH (month, day, and year) Sept. 2 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Hufnagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fuhrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Geo. F. Appell
(Address) 2021 Ashland Ave

15 Filed DEC 26 1924 19.... ROBERT R. KRAUTZ, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17

I HEREBY CERTIFY, That I attended deceased from June 10 1924 to Dec 22 1924

that I last saw her alive on Dec 21 1924,

and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Albert Abbott, M. D.

12/23 1924 (Address) Maplewood & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 26 1924
20 UNDERTAKER	**ADDRESS**
Geo M. Emill & Son	811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION of deceased is very important. See Instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 93279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93279

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1907 N. Payson ST., 15 WARD)

2-FULL NAME Mary Catherine Dorsch

(a) RESIDENCE NO. 1907 N. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Jan. 19th. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Dorsch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Hagan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant J. George Dorsch
(Address) 3210 Elgin Ave Walbrook

15 Filed DEC 26 1924, 192 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said enquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history. Found dead in cellar (duration) yrs. mos. ds.

(Signed) J. F. Hennessy, M. D. (Coroner.)

Dec. 25, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 12/26 192

20 UNDERTAKER H. C. Mears & Son

ADDRESS 908 Edmondson Ave Per R Wheeler

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 93280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2913 E. Monument St., WARD)

2-FULL NAME Elizabeth J. Burnett

(a) RESIDENCE NO. 2913 E. Monument St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Thos W Burnett

6 DATE OF BIRTH (month, day, and year) Oct 22-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa Pa Pa

PARENTS

10 NAME OF FATHER John F Wiseman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa Pa Pa

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa Pa Pa

14 Informant Thos W Burnett

(Address) 2913 E Monument St

15 Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1924, to Dec. 23, 1924,

that I last saw her alive on Dec. 22, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Schmitz, M. D.

Dec 24 1924 (Address) 701 Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec 26 1924

20 UNDERTAKER Robt J Turner Inc

ADDRESS 42 N Bond

N. B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY in years, months and days. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93281

CERTIFICATE OF DEATH.

D 93281

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 309 S. 3rd (St.:) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Rose

(a) RESIDENCE. No. 309 S. 3rd St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Rose

6 DATE OF BIRTH (month, day, and year): Oct 12-1850

7 AGE: Years 74; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel Cleaning Dept

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elizabeth Rose

(Address) 309 S Third St

15 Filed ....., 19.....

Registrar

DEC 26 1924

ROBERT R. KOESTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st 1924, to Dec 24 1924, that I last saw him alive on Dec 24 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at

Did an operation precede death? Yes Date of Oct 17/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Phi Gilbert Arlitz M. D.

, 19 (Address) 2942 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER: Robt J Turner

ADDRESS 1442 E Broadway

mation should be carefully supplied. Exact statement of OCCUPA-
that it may be properly classified. Exact statement of
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1660 2

HEALTH DEPARTMENT—CITY OF BALTIMORE

1660 93282 ✓ 1320 93282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harris

(a) RESIDENCE No. 4497 [illegible] Washington D. C. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robt. O. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliz. Bristow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 26 1924 19 ROBERT R. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24-1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 - 1924 to Dec 24 - 1924.
that I last saw him alive on Dec 24 - 1924,
and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Renal Calculi
Bilateral Pyonephrosis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia
(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Lives in Washington

Did an operation precede death? Yes Date of Dec 12-1924

Was there an autopsy? Yes

What test confirmed diagnosis? Examn of Kidneys -

(Signed) Winfield W. Scott M.D.

1924 (Address) Johns Hopkins Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. DATE OF BURIAL 12/28 1924

20 UNDERTAKER Wm J Tichnor & Sons ADDRESS 200 N Pa Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93283

CERTIFICATE OF DEATH.

89 D 93283

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 N. Fulton Ave ST., 16 WARD)

2-FULL NAME Howard Easter Hedley

(a) RESIDENCE NO. 813 N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~ Mamie Hedley

6 DATE OF BIRTH (month, day, and year) Mar. 29-1875 Guess

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. Hedley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rebecca Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Mrs. Hayden (Address) 813 N. Fulton

15 Filed ..... 192.. Registrar

DEC 26 1924 ROBERT M. ARMISTEAD Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 24, 1924 (Address) 2802 Eastman Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 26 192 4

20 UNDERTAKER Wm J Ecknert & Sons — ADDRESS N. Y Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 93284

CERTIFICATE OF DEATH

31 B 93284

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 12 Wilson Terrace WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Arthur W. Fulda

(Residence in Baltimore: No. 12 Wilson Terrace St.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: June 16, 1894 (Month) (Day) (Year)

7 AGE: 30 yrs. 6 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Motor Installer
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chas A Fulda

11 BIRTHPLACE OF FATHER (State or country): Balto

12 MAIDEN NAME OF MOTHER: Kristina Fetsch

13 BIRTHPLACE OF MOTHER (State or country): Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. A. Fulda

(Address) 12 Wilson Heights Ave

15

Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 24, 1924 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1924, to Dec 24 1924 that I saw h[illegible] alive on Dec 24 1924, and that death occurred, on the date stated above, at 4.35 p.m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(Duration) 5 yrs. mos. ds

Contributory (SECONDARY) Acute Cold (Duration) yrs. 4 mos. ds.

(Signed) Wm D Lucas M.D.

Dec 24, 1924 (Address) Corner Southern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cem — DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER: Wm J Buckner & Sons — ADDRESS: N & Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93285

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 223 S. Caroline St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hinda Wolfe

(a) Residence No. 223 S. Caroline St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Zelic Wolf

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Mechem Caron

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Ethel —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1429 E. Balto St.

15- Filed DEC 26 1924 ROBERT R. REA Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/25/24

17- I HEREBY CERTIFY, That I attended deceased from Oct., 1924 to Dec. 24, 1924

that I last saw h[illegible] alive on Dec. 24 1924

and that death occurred, on the date stated above, at 7:45 m.

The CAUSE OF DEATH* was as follows:

mitral regurgitation

chronic myocarditis

arteria - Sclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) angina Pectoris

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. P. Michelsen M. D.

, 19 (Address) 2230 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Herring Run

DATE OF BURIAL, 12/26 19 24

20-UNDERTAKER, Jack Lewis

ADDRESS 1429 E Balto St

Burial Permit Clark.

Endorse so carefully, supplying omissions, as to be properly classified. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93286

CERTIFICATE OF DEATH.

D 93286

1-PLACE OF DEATH Roland ave & University Parkway REGISTERED NO. 58

CITY OF BALTIMORE: (No Chadford Apts ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chadford Apartments Nellie A. Coughlan

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robt E. Coughlan

6 DATE OF BIRTH (month, day, and year): Aug 25. 1880

7 AGE — Years: 44 — Months: 3 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: home duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas W. Wheatley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Amelia Colbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robt E. Coughlan (Address) Chadford apartments

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-24 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1924, to 12-24, 1924.

that I last saw her alive on 12-23, 1924.

and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

PROGRESSIVE CENTRAL MUSCULAR ATROPHY

(duration) 7 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes. Johns Hopkins Hospital

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) 1129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER, ADDRESS: John Mitchell 1201 W. Fayette St

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: No. 1618 Druid Hill Ave St., 14 Ward) 101-001 D 93287 Registered No.

2-FULL NAME Edmund Dent

(a) Residence No. 1618 Druid Hill Ave St., Ward
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male | 4-COLOR OR RACE, Col | 5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 2-11-1923

7-AGE, yrs. 10 mos. 13 ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md

PARENTS.
10-NAME OF FATHER Randolph Dent
11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country) Md
12-MAIDEN NAME OF MOTHER Frances Somerville
13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Md

14- (Informant) Frances Dent
(Address) 1618 D. H. Ave

15-
Filed ..... 192.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-24-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 1924, to Dec 23 1924, that I last saw h— alive on Dec 23 1924, and that death occurred, on the date stated above, at 8 a.m.
The [illegible] DEATH was as follows:

(1) Peter Pneumonia

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? (Duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Carl Pfannenstiel M. D.
Dec 24, 1924 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL Dec 26 1924

20-UNDERTAKER Clarence Wright | ADDRESS 1364 McCulloh

Should be carefully prepared so that it may be properly classified. Exact statement of OCCUPATION is very important, in plain terms, so that it may be instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Roland Pk. 11-01

D 93288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Somerset Rd. & Kitley Lane ST., 57 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Quinn

(a) RESIDENCE NO. Somerset Rd. & Kitley Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Quinn

6 DATE OF BIRTH (month, day, and year) Feb. 2 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doer, Beer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kilroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rev. T. F. Quinn

(Address) Frederick Md

15 Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19 1924, to 12/24 1924, that I last saw him alive on 12/24 1924, and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

following Grippe

(duration) yrs. 8 mos 7 da.

CONTRIBUTORY (Secondary) Myocarditis, (duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm F. Quinn, M. D.

, 19 (Address) Upland Pa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys. Govans DATE OF BURIAL Dec 27 1924

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Rd

mation should be carefully supplied. AGE should be given in YEARS whenever possible. If LESS than a day, hours or minutes may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

93289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 615 Claymont Ave 16 Ward)

Registered No. 1929 93289

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Arnot Lyle Carruthers

(a) Residence No. 615 Claymont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single, Married,~~ Widowed, ~~or Divorced~~ (Write the word.) Widow

5a-If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Charles J Carruthers

6-DATE OF BIRTH (month, day and year) Sept 9 1836

7-AGE. 88 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Stone M

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Thomas J Beach

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Mary J Stallings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14-

(Informant) Mrs F Lorenco Gerhard

(Address) 615 Claymont Ave

15-

DEC 26 1924 ROBERT R. KRAUTER,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) DEC 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 8, 1924, to Dec 24, 1924,

that I last saw h.. alive on Dec 24, 1924,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary test

(Signed) Wm Michel, M. D.

, 19 (Address) 2401 Edmondson Ave

DEC 27 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~. London Park

DATE OF BURIAL. DEC 27 1924

20-UNDERTAKER. Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93290

CERTIFICATE OF DEATH.

101-001

D 93290

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest B. Dorsey

(a) RESIDENCE No. 2313 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hattie Dorsey

6 DATE OF BIRTH (month, day, and year) Sept. 1- 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer) Regular duties Janitor

(c) Name of employer Joseph T. Corkery

9 BIRTHPLACE (city or town) (State or country) Balto City Md.

PARENTS

10 NAME OF FATHER Frank Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co. Md.

14 Informant Elizabeth Dorsey

(Address) 2327 Division St.

DEC 26 1924 ROBERT R. KNUTER, Registrar

Filed ..., 19.. Baltimore Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22- 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14- 1924 to Dec. 22- 1924, that I last saw him alive on Dec. 21- 1924, and that death occurred, on the date stated above, at 10-30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) - yrs. - mos 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) - yrs. - mos. 6 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physicial Exam.

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 24 1924

20 UNDERTAKER Joseph A Farrell

ADDRESS 2317 Div

mation should be carefully supplied. Age, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93291

CERTIFICATE OF DEATH.

90 D 93291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1307 Belair Road ST., 8 WARD)

2-FULL NAME Catherine B. Franz.

(a) RESIDENCE NO. 1307 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? 78 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced (~~HUSBAND~~) of (or) WIFE of Peter Franz

6 DATE OF BIRTH (month, day, and year) Feb. 26 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Baugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Adam Weilman

(Address) 1307 Belair Road

15 Filed ....., 19 ..... ROBERT B. KRAUTER, Registrar

DEC 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1924, to Dec 24, 1924, that I last saw h~~er~~ alive on Dec. 24, 1924, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with dilatation

(duration) Not definite yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) Not definite yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Benj. F. Hayden, M. D.

12/25 1924 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 131 E Eager St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 93292

Registered No.....

1-PLACE OF DEATH St. Joseph's Hosp

City of BALTIMORE: (No..... St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M Gossman

(a) Residence No. 2874 Hanford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Mathilda L Gossman

6-DATE OF BIRTH (month, day and year) May 25 1863

7-AGE. 61 yrs. 7 mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Gossman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Hiland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Mathilda L Gossman
(Address) 2874 Hanford Ave

15- Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec 24, 19 24, to Dec 25, 19 24, that I last saw him alive on Dec 25, 19 24, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Sybert M. D
19 (Address) St Jos. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer Cemy	Dec. 29 1924
20-UNDERTAKER, Henry Stock Son	ADDRESS 1301 E Eager St

Should be carefully prepared, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93293

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 N. Eden ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis X. Stellein

(a) RESIDENCE NO. 1330 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary L. Stellein

6 DATE OF BIRTH (month, day, and year) Dec. 18 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter at

(b) General nature of industry, business, or establishment in which employed (or employer): C. Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Stellein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Mary L. Stellein

(Address) 1330 N. Eden St

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

DEC 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25th 1924

17

I HEREBY CERTIFY, That I attended deceased from December 20 1924, to December 25 1924, that I last saw him alive on December 25 1924, and that death occurred, on the date stated above, at 4.01 A.M.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis - Chronic Colitis - Pleurisy (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William H. Schwartz M. D.

12/25, 1924 (Address) 1200 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 29 1924
20 UNDERTAKER	ADDRESS
Henry Hook Son	1301 E Lanvale

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93294

HEALTH DEPARTMENT—CITY OF BALTIMORE

1850 93294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME R. Cole Gliss

(a) RESIDENCE No 63 Echodale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23rd 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Switch man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C & P Telephone Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William F. Gliss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Pearl M. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William F. Gliss
(Address) 63 Echodale Av. Hamilton

15 Filed DEC 26 1924, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) yrs. mos. 3 hours ds.

CONTRIBUTORY (Secondary) Fell from Telephone Pole

(Duration) yrs. mos. ds.

(Signed) Geo. P. Horton M. D.
(Coroner)

Dec. 25 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec 27 1924
20 UNDERTAKER	ADDRESS 1034 Hanover St
C. Schlosman & Son	

IMPORTANT. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Blks.

D 93235

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 93295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Madison ave ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Sherry

(a) RESIDENCE No. 2225 Madison ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 41 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Sherry

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing
(c) Name of employer merchant

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bernard Sherry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Untown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Bernard Sherry
(Address) 2225 Madison ave

15 Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) [signature], M. D. (Coroner.)

Dec 26, 1924 (Address) 3502 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Wilson Southern ave	12/26 1924
20 UNDERTAKER	ADDRESS
Jack Levis	1439 E Baltimore

CAUSE OF DEATH to be plainly written, so that no mistake may occur in copying of certificate.
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93296
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1503-E. Lafayette Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Della V. Twigg

(a) Residence No. 1503-E. Lafayette Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thos. F. Twigg

6-DATE OF BIRTH (month, day and year) 5/15/87

7-AGE. 37 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Dorchester Co. (State or Country), Md.

PARENTS.

10-NAME OF FATHER Wm. Lewis

11-BIRTHPLACE OF FATHER (city or town) Dorchester Co. (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lillian Parks

13-BIRTHPLACE OF MOTHER (city or town) Dorchester Co. (State or Country), Md.

14- (Informant) Capt. Lupo Twigg

(Address) 1503-E. Lafayette Ave.

DEC 26 1924

..... 192 ROBERT R. YEATES Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 1924 to Dec 25 1924 that I last saw her alive on Dec 23 1924 and that death occurred, on the date stated above, at 6308 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardio Asthenia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Albert L. Levy M.D.

(Address) 1707 E. Madison St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cambridge Md.	Dec 26 1924
20-UNDERTAKER Geo. J. Ruth	ADDRESS 1735 Harford

Should be carefully filled in plain terms, so that it may be properly classified. Exact statement of occupation necessary. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93297

CERTIFICATE OF DEATH.

D 93297

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss anna K. Schulke

(a) RESIDENCE NO. Homestead Apts ST. St Paul & 31st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	57	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife do do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. Ida Farren

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. George Schulbe

11 BIRTHPLACE OF FATHER (city or town) Hesse (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Margaret Müller

13 BIRTHPLACE OF MOTHER (city or town) Hesse (State or country) Germany

14 Informant Mr. George P. Schulbe

(Address) Rolling Road Catonsville

DEC 26 1924

Filed ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23/. 1924. to Dec 24/. 1924. that I last saw her alive on Dec 24 . 1924. and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

24 hours — — —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dorf Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Schulke M. D.

. 19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL Dec 26 1924

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Park Ave

AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D 93298

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: No. Bay View Asylum St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Bell

(a) Residence No. 1118 China Strat St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where died here mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS

10-NAME OF FATHER Lewis Bell

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Harriet Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14-Informant Hospital Records

(Address) Bay View Hospital

Filed DEC 26 1924 ROBERT R. K... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-22-24.

17- I HEREBY CERTIFY, That I attended deceased from 12-20-24 to 12-22-24 that I last saw h[illegible] alive on 12-22-24 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Urinary extravasation of Scrotum Perineum & Abdominal wall Consultant Gangrene of Scrotum & Urethral Stricture gonorrheal in Origin (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-20-24.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) H. F. Cowper Jr. M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. MT Auburn Ex DEC 26 1924

20-UNDERTAKER. A. K. Brown & Son ADDRESS 1018 Mulberry

Instructions to Physicians: Every case of death must be reported to the Health Department within 24 hours after death occurs. Causes of death must be stated in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

Emma Lyles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93299

CERTIFICATE OF DEATH.

101 D 93299

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Lemon st ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Lyles

(a) RESIDENCE NO 820 Lemon st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colo	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Don't Know

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 610
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Lottie Lyles
(Address) 820 Lemon St

15 Filed DEC 26 1924, 192 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

CAUSE OF DEATH in plain terms. No abbreviations or terms of doubtful meaning. See instructions on back of certificate. TION is very important

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

2 weeks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. H. Grinnell, M. D. (Coroner.)

12, 24, 192 (Address) 1727 Dawson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Dec 29 1924
20 UNDERTAKER Wm. Braun & Son	ADDRESS 1018 W Mulberry

Cor.—1-12-25—M&T—100 Bks.

D 93300

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 93300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Olive St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Ware.(C)

(a) RESIDENCE NO. 1114 1/2 Olive St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Widow.

5a If ~~married, widowed, or~~ divorced, (or) WIFE of Reuben Ware.(C)

6 DATE OF BIRTH (month, day, and year) October 12, 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Walter Jones.(C)
(Address) 1114 1/2 Olive St.

15 Filed ... 192 ... Registrar

DEC 26 1924 ROBERT R. KRAUTER, Asst. Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 21, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

Dec. 25, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	26/12 1924
20 UNDERTAKER	ADDRESS
Francis Brownston	108 W Monto

Spec.—1-10-21—M&T—1500 Bks.

D 93301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12/D 93301

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2850 W. North Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Catherine Wood

(a) RESIDENCE No. 2850 W. North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Wood

6 DATE OF BIRTH (month, day, and year) July 31, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph B. Downs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth A. Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Wood

(Address) 2850 W. North Ave.

15 Filed DEC 26 1924, 19 ROBERT R. ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1924, to Dec 23, 1924, that I last saw her alive on Dec 22, 1924, and that death occurred, on the date stated above, at 12.50 p m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis,

(duration) few yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bunnan Ford, M. D.

12/24 1924 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem.	Dec 26 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Eight

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D 93302

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 Marshall St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Taylor

(a) Residence No. 1518 Marshall St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John T Taylor

6-DATE OF BIRTH (month, day and year) Oct 17 1850

7-AGE. 74 yrs. 2 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Dont Know

14- (Informant) Mrs Mattie E Connors

(Address) 2 South 3rd st Brooklyn Md

15- Filed ..... 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25/924

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to Dec 25 1924 that I last saw h. alive on Dec 24 1924 and that death occurred, on the date stated above, at 1.30 a.m. The CAUSE OF DEATH* was as follows:

Cancer of face

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Dec 24 1924 (Signed) R. K. Campbell M. D. (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill	Dec 27. 1924
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

DEC 26 1924 Burial Permit Issued

In plain terms, so that it may be properly classified. Exact statement of cause of death. Follow instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93303

CERTIFICATE OF DEATH.

75 B 01 ✓ B 93303

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1125 6th ST. 17 WARD)

2-FULL NAME Louis Nelson

(a) RESIDENCE. No. 1125 Eltonia ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 60 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Wilson

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	83	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer none for yrs.

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Stephen Nelson

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Melinda

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mary Wilson
(Address) 1125 Eltonia St.

15 Filed ..... 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 23.

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1924, to Dec 22, 1924, that I last saw h— alive on Dec 21, 1924, and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Age. Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal

(Signed) W. H. Wright, M. D.

(Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Dec 26 1924

20 UNDERTAKER Samuel T. Krusen, Jr. ADDRESS 578 Bdle

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

93304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93304

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Blake—

(a) RESIDENCE NO 1213 W Lanvale— ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phoebe Blake

6 DATE OF BIRTH (month, day, and year) Feb 25 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Not Indick
(State or country)

PARENTS

10 NAME OF FATHER Daniel Blake

11 BIRTHPLACE OF FATHER (city or town) West Indies Island
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Phoebe Blake
(Address) 1213 W Lanvale St

15 Filed DEC 26 1924 ROBERT R. KRAUFER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... ~~Inquest, autopsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Greene, M. D.
(Coroner.)

12-26, 1924 (Address) 1127 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem

DATE OF BURIAL Dec 30 1924

20 UNDERTAKER Samuel F. Hinkley

ADDRESS 1128 W Baltimore

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

33047
17684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 100-D 93305

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Franklin Pidgeon

(a) RESIDENCE No. Sparrows Point ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Vincent Pidgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fay Kasper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Reside

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 10 - , 1924, to Dec 24 - , 1924, that I last saw him alive on Dec 24 - , 1924, and that death occurred, on the date stated above, at 10 00 P. m.

The CAUSE OF DEATH* was as follows:

Secondary anaemia
(nutritional)

(duration) yrs. 4 mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund H Kemper, M. D.

Dec 27, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Dec. 26 1924

20 UNDERTAKER John M Weber ADDRESS 803 Bond St

mation should be carefully supplied. Accurate
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93306 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93306

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1723 Eastern Avenue St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva . Maciejewski

(a) Residence No. 1723 Eastern Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 25 1924

7-AGE: ...yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or. 45 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER, John Maciejewski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary Lewczak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Mr. John. Maciejewski

(Address) 1723 Eastern Avenue

15- Filed DEC 26 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 25/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1924 to Dec 25, 1924

(last I last saw h... alive on Dec 25, 1924

and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Breech presentation 1 mother

(Duration) ...yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatorum 7 days

(Duration) ...yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. M. Sutherman, M. D.

Dec 26, 1924 (Address) 2210 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, Dec. 26 1924

20-UNDERTAKER, John Ingelberg ADDRESS 1803 Bank

Ed. Exact statement of occupation is desired. Entries must be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

KEEP SAFELY

Cor.—1-12-23—M&T—100 Bks.

D 93307

HEALTH DEPARTMENT—CITY OF BALTIMORE

1803 ✓

D 93307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian W. Seitz

(a) RESIDENCE NO 17 Anthony Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4fo yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charlotte Seitz

6 DATE OF BIRTH (month, day, and year) Feb 15/1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer) Building Construction
(c) Name of employer William Gagan

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Seitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Charlotte Seitz
(Address) 17 Anthony Ave

15 Filed ..., 192 ... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (base)

Struck by automobile

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Pallen, M. D.
(Coroner.)

12/26/24 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 27 1924
20 UNDERTAKER Fred'k Loose & Son	ADDRESS Fullerton

TION is very important. See instructions on back of certificate.

12-23-21—E.B.R.S.—400 Bks.

93308 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 D 93308

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 646 W. Fayette St., 4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME August Weaver

(a) Residence No. 646 W. Fayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Weaver

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) City Hand Laundry

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Louis Weaver

(Address) 319 S. Poyson St.

15- Filed DEC 26 1924 E. B. KRAUTER, Registrar. Assistant Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1924 to Dec 24 1924

that I last saw h— alive on Dec 24 1924

and that death occurred, on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Endocarditis

Contributory Acute Dilatation

Uncertain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Klopman M. D.

Dec 25, 1924 (Address) 2602 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL, Dec 27 1924

20-UNDERTAKER. J. H. Cook — ADDRESS 532 E. Fayette St.

in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

12-23-2 — E.E.R.S.—400 Bks.

93308

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 93308

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 646 W. Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Brewer

(a) Residence No. 646 W. Fayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Elizabeth Brewer

6-DATE OF BIRTH (month, day and year): unknown

7-AGE: 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): City

(c) Name of employer: Road Laundry

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Louis Wagner

(Address): 919 S. Poyson St.

15- Filed DEC 26 1924 E. R. KRAUSER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 25-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1924 to Dec 24 1924

that I last saw h— alive on Dec 24 1924

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Contributory Acute Dilatation

(Secondary)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Klosowski, M. D.

Dec 25 1924 (Address) 2202 Wakefield Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity — DATE OF BURIAL: Dec 27 1924

20-UNDERTAKER: W. Cook — ADDRESS: 532 E. Fayette Ave

In plain terms, so that it may be properly classified. Follow instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1314 William St., 27 Ward)

Registered No. 81

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John J. Walsh

(a) Residence No. Hamilton Ave. Raspburg Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida E. Walsh

6-DATE OF BIRTH (month, day and year) June 29-1867

7-AGE. 57 yrs. 5 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 061

(b) General nature of industry, business, or establishment in which employed (or employer) Police sargeant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS:

10-NAME OF FATHER. Michael H. Walsh

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Blake

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Ida E. Walsh

(Address) 1314 William St.

15- Filed DEC 26 1924 By: ROBERT R. KRAUSE Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12. 23. 24

17- I HEREBY CERTIFY, That I attended deceased from 12. 18. 24 to 12. 23. 24

that I last saw him alive on 12. 23. 24

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Aortitis

Don't Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Vectoris

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? examination

(Signed) Edward Morris M. D

12. 26. 24 (Address) 107 E West St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Catholic Cem. DATE OF BURIAL. Dec 27. 1924

20-UNDERTAKER. J. A. Krause & Son ADDRESS 703 Hanover St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93310

CERTIFICATE OF DEATH.

D 93310

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3509 Windsor Mill Road St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Ewin Bonn

(a) Residence No. 3509 Windsor Mill Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 ~~11~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony S.Bonn

6-DATE OF BIRTH (month, day and year) Mar.13,1845

7-AGE, 79 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None (W)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Randolph County West Virginia

PARENTS.

10-NAME OF FATHER, William Ewin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Dennis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) William E.Bonn

(Address) 3509 Windsor Mill Road

15- Filed DEC 26 1924 16 ROBERT R. KRAUTER, Registrar. Burial Permit Given

In place of name, or when not known, give particulars required by instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec.25,1924

17- I HEREBY CERTIFY, That I attended deceased from October, 1924, to Dec. 25th, 1924, that I last saw her alive on Dec. 24th, 1924, and that death occurred, on the date stated above, at 7.50 A.m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis Chronic Bronchitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. F. Lellmann M. D.

12-26, 1924 (Address) 8 E.Eager Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL, Dec 27 1924

20-UNDERTAKER. Joseph B Cook ADDRESS 1003 N. Balto

Spec–12-23-21–E.B.R.S.–400 Bks. (2005 Eutaw Pl.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93311 — CERTIFICATE OF DEATH. — 12 58-001 ✓ — D 93311

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St.,) 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Miss Mary C. Barrett 2005 Eutaw Pl.

(a) Residence No. 111 E. Lafayette Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 1865

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Edward Barrett

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Thos E. Barrett

(Address) 3007 St. Paul St

15- Filed DEC 26 1924, 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 24th

17- I HEREBY CERTIFY, That I attended deceased from Aug. 4 1924, to Dec. 24 1924, that I last saw him alive on Dec. 24 1924, and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. Theodore M. D

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. 12/27/1924

20-UNDERTAKER. E. J. Fanning Undr. — ADDRESS 1338 E. Lafayette

In plain terms, so that it may be properly classified. Exact statement of cause of death. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93312

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 93312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 N. Eutaw ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Olive Perkins

(a) RESIDENCE NO. 621 N. Eutaw ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 0 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elijah L. Perkins

6 DATE OF BIRTH (month, day, and year) Nov. 28 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer wife

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER Augustus Seibel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Mitchell Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elijah L. Perkins

(Address) 621 North Eutaw

15 Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25 1924 to Dec 25 1924, that I last saw h[illegible] alive on Dec 25 1924, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH was as follows:

Acute Myocarditis

(duration) yrs. sudden mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. W. Phillips M. D.

19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	12/29/24
20 UNDERTAKER	ADDRESS
Geo. Nibel & Son	2503 Edmondson

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1805

D 93313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93313

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 312 Birchwood Av ST. (Hamilton) WARD 27

2-FULL NAME Marie L. McKee

(a) RESIDENCE NO. 312 Birchwood Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert L.

6 DATE OF BIRTH (month, day, and year) Sept 25 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	27	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 27

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Luther Sunderland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Teresa Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robert L. McKee

(Address) 312 Birchwood Ave

15 Filed Robert P. Harrison, Registrar

26 1924 Burial Permit Mark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from FEB 5TH, 1924, to DEC 24TH, 1924, that I last saw HER alive on Dec 24th, 1924, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Vasomotor Myocardial insufficiency

Unknown (duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? Examination of sputum

(Signed) Amelia V. Zimmerman, M. D.

, 1924 (Address) 1805 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Dec	27 1924
20 UNDERTAKER Wm Cook & Son	ADDRESS

mation should be carefully supplied. Exact statement of occupation should be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93314

CERTIFICATE OF DEATH.

74-006

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Riggs Ave. ST., 16 WARD)

2-FULL NAME Mally Satchell

(a) RESIDENCE NO. 1520 Riggs ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Satchell

6 DATE OF BIRTH (month, day, and year) July 10, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Iza. Greasen

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Greasen

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mattie Turnstall
(Address) 1520 Riggs ave

15 Filed DEC 26 1924, 192 Robert F. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24th 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec 24, 1924 (Address) 220 Mun Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec 31 1924

20 UNDERTAKER Virginia G. Brooks

ADDRESS 1411 N. Carey

match should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 E. Wheldrake St., 12 Ward) REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dingley

1a) RESIDENCE. No. 326 Wheldrake St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23, 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10 hrs	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Etta Cecila Quigley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed . 19 Robert E. Harrison Registrar

DEC 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1924, to Dec 24, 1924, that I last saw him alive on Dec 23, 1924, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis Mother

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas L. Hoopes, M. D.

, 19 (Address) 3467 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 24 1924
20 UNDERTAKER	ADDRESS
Commissioner Health.	

Per Wm. E. WINDSOR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 93316 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 415 S. Regester St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Hartman

(a) Residence No. 415 S. Regester St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eva Hartman

6-DATE OF BIRTH (month, day and year) June 29th 1857

7-AGE.	If LESS than 1 day,
67 yrs. 6 mos. 25 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mill Employe

(b) General nature of industry, business, or establishment in which employed (or employer): 046

(c) Name of employer:

9-BIRTHPLACE (city or town) Balto (State or Country) Md.

PARENTS.

10-NAME OF FATHER, John Hartman

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country).

12-MAIDEN NAME OF MOTHER, Kunigunda

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country).

14- (Informant) Eva Hartman (Wife)

(Address) 415 S. Regester St.

15- Dec 26 1924 Robert E. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 23/24

17- I HEREBY CERTIFY, That I attended deceased from 4/2 19 24 to 12/23 19 24

that I last saw him alive on 12/23/24 19 24

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Primary)

and

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Daniel D Jenkins, M. D

, 19 24 (Address) 3320 Pall Pl. Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	Dec 27. 19 24
20-UNDERTAKER.	ADDRESS
Lilly + Zeiler	403 S. Wolfe St

in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93317

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-801

D 93317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1117 Olive St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jesse Pearson

(a) Residence No..... St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 13/24

7-AGE. ..... yrs. ..... mos. 13 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Harry Pearson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Leathea Jackson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Leathea Pedgson

(Address) 1117 Olive St.

15- Filed DEC 26 1924 192... Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 25/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13 19 24 to Dec. 25 19 24

that I last saw him alive on Dec. 25 19 24

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) M. Alexander Mowry M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL DATE OF BURIAL, ..., 19....

20-UNDERTAKER. Commissioner Health ADDRESS DEC 26 1924

DEC 26 1924

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93318

CERTIFICATE OF DEATH.

D 93318

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 Cedar St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Waloga

(a) Residence No. 19 Cedar St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Waloga

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Austria

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14- (Informant) Sophie Waloga

(Address) 19 Cedar St.

15- Filed DEC 25 1924, 192.. Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1924 to Dec 25 1924

that I last saw him alive on Dec 26 1924

and that death occurred, on the date stated above, at 2.01 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Leon D. Rorca M. D

Dec 26 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Dec. 29, 1924

20-UNDERTAKER,	ADDRESS
Paul E. Crockett	1906 Eutaw

Should be clearly written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Pks.

D 93319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93319

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 937 N. Collington Ave St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Miller

(a) Residence No. 937 N. Collington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? 90 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Celestin Miller

6-DATE OF BIRTH (month, day and year): Jan 25 1855

7-AGE: 68 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or. ...min.?

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Mid-Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Bohemia

PARENTS.

10-NAME OF FATHER: Center Bernals

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Bohemia

12-MAIDEN NAME OF MOTHER: Centonie Marrousek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Bohemia

14-(Informant) Celestin Miller
(Address) 937 N. Collington Ave

15-Filed DEC 26 1924 Robert F. Harrison Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 24/24

17-I HEREBY CERTIFY, That I attended deceased from Dec 21 24 to Dec 24 24
That I last saw him alive on Dec 24 24
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

Signed: Dec 24 19 (Address) 900 N. Monroe St. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross	Dec 26 1924
20-UNDERTAKER. Frank Eccleston	ADDRESS 1900 Eutaw

in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 93320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93320

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 N. Gilmor St. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Parrish

(a) RESIDENCE NO. 1130 N. Gilmor St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1922 (Guess)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	17 days	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph W. Parrish

11 BIRTHPLACE OF FATHER (city or town)
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Maggie Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Joseph W. Parrish
(Address) 1130 N. Gilmor St.

15 Filed DEC 28 1924 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd degree burns of body. (accidental)

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. T. Hennessy, M. D.
(Coroner.)

Dec. 26, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Suffolk Va	DEC 26 1924
20 UNDERTAKER	ADDRESS
Saml H. Chase & Son	1400 Mosher

THION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 93321

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1932 Penrose Ave ST., 20 WARD)

2-FULL NAME Annie T. Whittemore.

(a) RESIDENCE NO. 1932 Penrose Ave, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	38	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walter Cadogan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Ellen Singleton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Nellie Gillespie (Address) 1932 Penrose Ave.

15 Filed ..... 19 Robert P. Harrison, Registrar

C 26 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 25th 1924.

17 I HEREBY CERTIFY, That I attended deceased from October 5th, 1923, to December 25th, 1924, that I last saw her alive on December 24th, 1924, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus with General Peritonitis.

(duration) 1 yrs. 3 mos ~ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D. Perkins, M. D.

Dec 27 1924 (Address) 1 West Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	DEC 27 1924

20 UNDERTAKER: Wm J. Hartwell ADDRESS 2236 E. Balto St.

ATTENTION REQUESTED BY REGISTRAR. Answer all questions, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, suppressing technical terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93322

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1008 S. Third St. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Crescentia Schenk

(a) Residence No..... 1008 S. Third St. St., 76 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Schenk.

6-DATE OF BIRTH (month, day and year) Sept. 6-1852

7-AGE. 72 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER Lawrence Weinbach

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant) George Schenk

(Address) 1008 S. Third St.

15- Filed 192 Robert P. Harrison, Registrar.

DEC 26 1924 Burial Permit Clerk

In plain terms, so that it may be properly examined. Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 23-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 19 24 to Dec 23, 19 24

that I last saw h alive on Dec 15, 19....

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) M. L. Burke, M. D.

, 192 (Address) 3942 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Sacred Heart Cem	Dec. 27, 1924
20-UNDERTAKER. Lilly & Ed Zeiler	ADDRESS 403 S. Wolfe St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93323

CERTIFICATE OF DEATH.

D 93323

Registered No. 1794

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave Ward 20)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary J. Wilbur

(a) Residence No. Home for the Aged of the M E Church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 24, 1840

7-AGE. 83 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Andrew Appold

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Annie Bagley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Helen E Bennett

(Address) 400 N Fulton ave

15- Filed Dec 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 26/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28 19 24 to Dec. 26 19 24

that I last saw h[illegible] alive on Dec. 25 19 24

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George C. Shannon, M. D.

12/26, 1924 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Dec 27, 1924

20-UNDERTAKER. George J Smith

ADDRESS 1532 Hollins St

In plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

B 93324

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 93324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 509 Radnor Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Reagan

(a) Residence No. 509 Radnor ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, W.

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Michael F. Reagan

6-DATE OF BIRTH (month, day and year) April 9-1860

7-AGE. 64 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Norfolk Va (State or Country),

PARENTS.

10-NAME OF FATHER, Daniel Robert

11-BIRTHPLACE OF FATHER (city or town) Ireland (State or Country),

12-MAIDEN NAME OF MOTHER, Hannora Sullivan

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country),

14-

(Informant) Wm. F. Leo. Reagan

(Address) 509 Radnor ave

15-

Filed Dec 27 1924 Robert F. Harrison Registrar.

C 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-24-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 19 24 to Dec 24 19 24

that I last saw him alive on Dec 24 19 24

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

Chron Int. Nephritis

Asthma

(Duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. W. Bishop M. D.

Dec 24 1924 (Address) 521 Sheridan Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, 12-27th 1924

20-UNDERTAKER, Harry C Brannigan Son — ADDRESS 517 N Schroeder St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ~~x~~ imp... See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

(Hossfeld)

D 93325

D 93325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hosp. — 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME John E. Hossfeld

(a) RESIDENCE NO. 2005 N. Monroe ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor A. Hossfeld.

6 DATE OF BIRTH (month, day, and year) June 27, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Hossfeld.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Eleanor Hossfeld
(Address) 2005 N Monroe St.

15 Filed ..... 19..... Registrar
6 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24. 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1924, to Dec 25 1924, that I last saw him alive on Dec 24, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Subacute bacterial Endocarditis (duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? P.E

(Signed) K. W. Gallagher, M. D.

, 19 (Address) M D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 12/27/1924

20 UNDERTAKER Harry A Wilke

ADDRESS 1531 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. Illegible or illegible CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 2

Spec- 12-23-21-E.B.R.S.-400 Bks.

D 93326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93326

32

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp. 20 Registered No.....

City of BALTIMORE: (No.....St., 20 .....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edward Mosberger

(a) Residence No. 3215 Strickland St. St., ...Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 25, 1884

7-AGE. 40 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS

10-NAME OF FATHER Theodore Mosberger

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.

12-MAIDEN NAME OF MOTHER Alice Reed

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md.

14- (Informant) C. J. Mosberger

(Address) 3215 Strickland St

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

DEC 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 24/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1924 to Dec 24 1924

that I last saw him alive on Dec 24 1924

and that death occurred, on the date stated above, at 11:20 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Duncan O'Clay M. D.

, 19 (Address) 33 W. Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holstein Cemetery	Dec 27 19 24
20-UNDERTAKER.	ADDRESS
Harry H. Writzke	1531 W. Lombard

in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93327

HEALTH DEPARTMENT—CITY OF BALTIMORE

93327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Argyle ave. ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brown

(a) RESIDENCE No. 928 Argyle ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis J. Brown

6 DATE OF BIRTH (month, day, and year): April 6 1874

7 AGE: Years 50 | Months 7 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 0'0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Sebastian Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary A Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Louis J. Brown 928 Argyle ave

15 Filed ....., 192 ..... Robert F. Harrison, Registrar

DEC 25 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) 1 yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 26, 1924 (Address) 2802 Eastern ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER: Samuel L. Wright

ADDRESS: 1364 Mary

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93328 93328

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 Eastern ave - St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Rattini

(a) Residence No. 806 Eastern ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) Dec 13-24

7-AGE, ... yrs. ..... mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER, Joseph A. Rattini

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country),

12-MAIDEN NAME OF MOTHER Annetta Genecco

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country),

14- (Informant) Annetta Rattini

(Address) 806 Eastern Ave

15- Dec 26. 1924 Robert P. Harris Registrar.

DEC 26 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 25 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 13, 19 24 to Dec 25, 19 24

That I last saw h[illegible] alive on Dec 25, 19 24,

and that death occurred, on the date stated above, at 5.0 m.

THE CAUSE OF DEATH* was as follows:

Convulsions due to

Spina Bifida

(Assisted Spina) 12 ds.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 1 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, Dec 27. 1924

20-UNDERTAKER, Martin W. C. Deppel — ADDRESS 31 S Green St.

Is plain terms, so that it may be properly classified. Exact information required. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93329

CERTIFICATE OF DEATH.

Registered No. 106-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 1503 Hanover St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Smith

(a) Residence No. 1503 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, ~~widowed~~ or ~~divorced~~ HUSBAND ~~of~~ WIFE of David L. Smith

6-DATE OF BIRTH (month, day and year) ? 1852

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Chicago Md.

PARENTS.

10-NAME OF FATHER, Patrick Brannan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) David L. Smith

(Address) 1503 Hanover St.

15- Filed Robert P. Harrison, Registrar.

DEC 27 1924

Deputy Health Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 24 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 19 22 to Dec 24 19 24

that I last saw her alive on Dec 23 19 24

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Stomach - Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

12-26, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral Cem.	Dec. 27 1924
20-UNDERTAKER	ADDRESS
Margaret A. Flynn	1422 Light St.

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93330

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3018 E. Fayette ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Thorn

(a) RESIDENCE NO. 3018 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 22/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER David A Thorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary C. Beirn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant David A. Thorn

(Address) 3018 E. Fayette st.

15 Filed 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1924, to Dec 26, 1924.

that I last saw h alive on Dec 24, 1924.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Traumatic Pneumonia

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Breast. Delirium

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Leyman, M. D.

12/26/1924 (Address) 728 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 27 1924

20 UNDERTAKER Jos. J. Kerr ADDRESS 156 N. Luzerne

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

D 93331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93331

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 305 S Eden St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominick Adamo

(a) Residence No. 305 S Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 30 1924

7-AGE. ...yrs. ...mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balt

PARENTS:
10-NAME OF FATHER, Tony Adamo
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy
12-MAIDEN NAME OF MOTHER, Carmila Lamaglia
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Tony Adamo
(Address) 305 S. Eden

15- Filed ... 192... Registrar.

DEC 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1924 to Dec 26 1924 that I last saw h[illegible] alive on Dec 26 1924 and that death occurred, on the date stated above, at 5.00 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ...yrs. ...mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary L. Cattalanotto M. D.

Dec 27 1924 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	December 1924
20-UNDERTAKER.	ADDRESS
Wendell Dryfoos & Son	378 Amr

in plain terms, so that it may be properly understood. Follow instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93332

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4602 O Donnell St., N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John W Nelson

(a) Residence No. 4602 O Donnell St,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Nelson

6-DATE OF BIRTH (month, day and year) Dec 9 1861

7-AGE. 63 yrs. ..... mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)..... 062

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto

PARENTS

10-NAME OF FATHER, George Nelson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Eliza Mills

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), New York

14- (Informant) Anna E. Nelson

(Address) 4602 O Donnell

15- Filed ..... 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 19 24 to Dec 25 19 24

that I last saw h[illegible] alive on Dec 24-24 19.....

and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) [illegible] M. D.

Dec 27 19 24 (Address) 29 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn	Dec 27 19 24

20-UNDERTAKER.	ADDRESS
Wendell Offel & Son	378 N

DEC 27 1924

Write plainly in plain terms, so that it may be properly classified. Exact statements of facts required. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93333

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SOUTH BALTO GEN'L HOSPT. 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ALBERT KIMMERLING

(a) RESIDENCE NO. 817 W. SARATOGA ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	SINGLE —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) MARCH 13 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) GERMANY

PARENTS

10 NAME OF FATHER ANTON KIMMERLING

11 BIRTHPLACE OF FATHER (city or town) (State or country) GERMANY

12 MAIDEN NAME OF MOTHER CHRISTINA ECHLICHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) GERMANY

14 Informant WIEGAND VOGEL
(Address) 817 W. SARATOGA ST

15 27 1924 Robert E. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 26, 1924

17

I HEREBY CERTIFY, That I attended deceased from NOV 12, 1924, to DEC 26, 1924
that I last saw him alive on DEC 26, 1924
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate + Bladder

(over)

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) J. E. Peterman, M. D.

19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 29 1924

20 UNDERTAKER: George J. Smith — ADDRESS: 1532 Hollins

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Rev—12-23-21—E.B.R.S.—400 Blks.

D 93334 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2103 Hollins St., 20 Ward) Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Schueler

(a) Residence No. 2103 Hollins St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Schueler

6-DATE OF BIRTH (month, day and year): June 21 1852

7-AGE: 72 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Ludwig Schultze

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs. Anna Keiting

(Address): 2103 Hollins St

15-

Filed 194 Robert T. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 19 24 to Dec 25 19 24

that I last saw her alive on Dec 25 19 24

and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Dementia

(Duration) yrs. mos. 6 weeks ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

12/27, 19 24 (Signed) C. H. Heuisler M. D.

(Address) 2000 Hollins

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: ~~Baltimore~~ Westminster Cem. | DATE OF BURIAL: Dec 29 1924

20-UNDERTAKER: Wm J Pickerhoff | ADDRESS: North & Pa

FEB 27 1925

in plain terms, so that it may be properly classified. Exact statement of occupation is required. Use instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93335

D 93335

CERTIFICATE OF DEATH.

118-501

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SOUTH BALTO. GEN. HOSP. 24 WARD)

2-FULL NAME MRS MARY FLEISCHER.

(a) RESIDENCE NO. 112 E. RANDALL ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEM	WHITE	WIDOWED -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Fleischer

6 DATE OF BIRTH (month, day, and year) May-12-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. C. Schultz Columbia & Clement Sts

DEC 27 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 24, 1924.

17 I HEREBY CERTIFY, That I attended deceased from DEC 20, 1924, to DEC 24, 1924, that I last saw h[illegible] alive on DEC 23, 1924, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

STRANGULATED VENTRAL HERNIA. (INCISIONAL)
(STRANGULATED 8 HOURS)
(duration) 15 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) SURGICAL SHOCK
(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? YES Date DEC 20

Was there an autopsy? NO

What test confirmed diagnosis? SIGNS & SYMPTOMS

(Signed) J. E. Peterman, M.D.

, 19 (Address) 1218 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 27 1924

20 UNDERTAKER: Wm J. Tickner & Sons — ADDRESS: Md Pa

mation sought is for CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

D 93336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93336

CERTIFICATE OF DEATH.

X 74-001

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4912 Wilson Ave (Ward) Arlington

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Watkins

(a) Residence No. 4912 Wilson Ave St., Ward Richmond Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. W. Watkins

6-DATE OF BIRTH (month, day and year) Oct 13 1852

7-AGE. 72 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), La.

PARENTS.

10-NAME OF FATHER, ? Anderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Amelia Cessna

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), La.

14- (Informant) Mrs. Wm. D. Carson

(Address) 4912 Wilson Ave

15- Filed Dec 27 1924 Robert E. Harrison Registrar.

Burial Permit Clerk.

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1924 to Dec 26 1924

that I last saw her alive on Oct 25 1924

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis - high blood pressure - parenchymatous nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage & Paralysis

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter E. Tubbitt M. D

Dec. 29 1924 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Richmond Va	Dec 28 1924
20-UNDERTAKER. Wm Fuckner & Sons	ADDRESS North & Pa

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93337

161-08 93337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pearl

(a) RESIDENCE NO. 714 Mennington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26. 24

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Carl S. Pearl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Gladys M Scherer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Carl S Scherer
(Address) Middletown Md.

Filed DEC 27 1924, 19

Robert F. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26 1924

17

I HEREBY CERTIFY, That I attended deceased from 6 PM 12/26, 1924, to 8 Pm 12/26, 1924

that I last saw h[illegible] alive on 12/26, 1924,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) K. W. Galley M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown Md

DATE OF BURIAL Dec 27 1924

20 UNDERTAKER Wm Cook

ADDRESS 102 E Hoill

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec—12-23-21—E.B R.S.—400 Bks.

D 93338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 190

City of BALTIMORE: (No. 217 Cole ave St., 26 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J MacKay

(a) Residence No. 217 Cole ave St., Ward 26
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lydia W Mackay

6-DATE OF BIRTH (month, day and year) June 4th 1862

7-AGE. 62 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Minister
(b) General nature of Industry, business, or establishment in which employed (or employer): 018
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), New Bedford Mass

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs Lydia MacKay
(Address) 217 Cole ave

15- Filed Dec 27 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 25th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1924 to Dec. 25, 1924 that I last saw him alive on Dec. 24th, 1924 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation
(Sudden Termination)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Milkman, M. D.

14/26, 1924 (Address) Bel Air Rd + Cole ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery DATE OF BURIAL, Dec 27th 1924

20-UNDERTAKER, George Schilling + Sons ADDRESS 926 E Monument St

Please write plainly, and follow instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93339

100-001

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Warrick Whitney

(a) Residence No. 5100 Wayne Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ Single (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 2, 1921

7-AGE, 3 yrs. 3 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child (boy)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) ~~Md~~ Va (State or Country),

PARENTS.

10-NAME OF FATHER, Kenneth E Whitney

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Eliz - Warrick

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country),

14- (Informant) Mother

(Address) same

15- Filed DEC 27 1924, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-26-24

17- I HEREBY CERTIFY, That I attended deceased from 12-21, 1924, to 12-26-, 1924, that I last saw h. alive on 12-26-24, 1924, and that death occurred, on the date stated above, at 4°° A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) - yrs. - mos. 11 ds.

CONTRIBUTORY (Secondary) none -

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) A B. Price, M. D.

, 19 (Address) Union Memorial Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL, Dec 27, 1924

20-UNDERTAKER, Robert Brookes Son — ADDRESS Cor Calhoun Hoffman Sts

In plain terms, so that it may be properly classified. See instructions on back of certificates.

KODAK S·A

Spec.—1-10-21—M&T—1500 Bks.

D 93340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93340

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5923 Falls Road (St.) 27 (Ward)

2-FULL NAME Sarah Margaret Buckley

(a) RESIDENCE NO. 5923 Falls Road ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.. min.
	46	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer at home

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Earlum Buckley

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Helen M Sutherland

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant George P. Buckley
(Address) 5923 Falls Road Balto Md

15 [illegible], 19 Registrar

C 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1924, to Dec 24, 1924, that I last saw her alive on Dec 21, 1924, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopical

(Signed) William J Todd M. D.

Dec 27, 1924 (Address) 1811 Washington Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL 12/27 1924

20 UNDERTAKER Henry W. Meakin Son — ADDRESS 641 N Calvert

mation should be entered in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93341

D 93341

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 751 Rubary ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaire Brown

(a) RESIDENCE NO. 751 Rubary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

123

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Chas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Julia Brown
(Address) 751 Rabary St

15 Filed DEC 27 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25-1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

(Signed) M K Gonsch, M. D.
(Coroner.)

12-27, 1924 (Address) 1177 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 27 1924
20 UNDERTAKER John H. Jordan	ADDRESS 40 and Hill

CAUSE OF DEATH must be plainly written; all questions must be answered. See instructions on back of certificate.
TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D 93342

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-006 93342

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2 WARD)

2-FULL NAME Anna Margaret Duschl

(a) RESIDENCE NO 2011 E. Lombard St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Dec 6/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
			20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work XXXX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Duschl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna M. Uhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johanna Duschl
(Address)

15 Filed 12 27 1924. 192 Robert F. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity-hemorrhage in cord & brain

(Autopsy at hopkins Hospital)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) John H Wallis, M. D.
(Coroner.)

12/27/24. 192 (Address) 500 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loly & Fridinger — DATE OF BURIAL 192

20 UNDERTAKER Lilly & Frieden — ADDRESS 403 S. Wolfe

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93343

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 93343

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 507 N. Wolfe St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Carrick

(a) Residence No. 507 N. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Wm J. Carrick

6-DATE OF BIRTH (month, day and year) Jan 5 76

7-AGE. 48 yrs. 11 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Chas. Sauerland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Caroline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Wm T. J. Carrick

(Address) 507 N. Wolfe St

15- Robert E. Harrison,

Filed 192 Registrar.

C 1924 Local Permit Clerk

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/24/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 19 24 to Dec 24 19 24

that I last saw h[illegible] alive on Dec 24 19 24

and that death occurred, on the date stated above, at 8-50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: William J Rosenau M. D.

(Address) 801 N Fremont

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL,
Balto Cem	12/27, 1924
20-UNDERTAKER. Philip Herrig	ADDRESS 2016 Arlington Ave

Cor.—1-12-23—M&T—100 Bks.

D 93344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Linden Wilson Ave. ST., 14 WARD)

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberta Hall

(a) RESIDENCE NO. 1109 Linden Wilson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1923 (query)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... (none)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wallace Hall

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lula Hill

13 BIRTHPLACE OF MOTHER (city or town) Ga.
(State or country)

14 Informant Wallace Hall
(Address) 1109 Linden Wilson Ave

15 Filed DEC 27 1924, 192 Robert F. Harrison, Registrar

Assistant Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held on enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) enquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

W. Whooping Cough.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) D. T. Hennessy, M. D. (Coroner.)

Dec. 27, 192 4 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 27 1924

20 UNDERTAKER Mrs Geo N. Dennis
Asst T. E. Kelson

ADDRESS 1303 Presstman St

CAUSE OF DEATH must be plainly written. Consult Physician if necessary. Study carefully the following instructions on back of certificate. ATTENTION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93345 ~~64~~ 1/72

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSP. 122

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 16 WARD)

2-FULL NAME James Allen.

(a) RESIDENCE No. 610 N. Pulaski St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallya Allen.

6 DATE OF BIRTH (month, day, and year) ? 1863.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 27 1924, 19 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26. 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924, to Dec 26, 1924, that I last saw h[illegible] alive on Dec 26, 1924, and that death occurred, on the date stated above, at 1 55 a.m.

The CAUSE OF DEATH* was as follows:

cirrhosis of the liver

(duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) jaundice

(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? inspection of liver

(Signed) E. Kolyza, M. D.

12/26 1924 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 29 1924
20 UNDERTAKER Joseph L. Cook	ADDRESS 10-3 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93346

93346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH On the street.

CITY OF BALTIMORE: (No. 1600 Druid Hill Ave. ST., 14 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Ward.

(a) RESIDENCE NO. 1409 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Perry D. Ward

6 DATE OF BIRTH (month, day, and year) about 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virg.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) 1409 Druid Hill Ave Perry D. Ward.

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said enquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Dec. 26, 1924 (Address) 1802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec. 29, 1924

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

mation should be carefully supplied. Age should be properly classified. Exact statement of occupation may be CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

EC 2 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 19 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hall

(a) Residence No. 313 N. Parish St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1872

7-AGE 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 19 Registrar.

Robert P. Harrison,

12 1924 Burial Permit Clerk

In plain terms, so that it may be properly classified, state the cause of death so as to indicate disease, nature of injury, and means by which injury was received. Do not use abbreviations or technical terms. Follow instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-24-24

17- I HEREBY CERTIFY, That I attended deceased from 8-9....., 1924, to 12-24, 1924, that I last saw h alive on 12-24, 1924, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic

Myocarditis (Degenerative);

Myocardial degeneration

(Duration) yrs. 6 mos. (Estimated)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Jones, M. D.

12-24, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec. 27, 1924

20-UNDERTAKER, Adolphus Hartd. ADDRESS 52 Hunters Lane. Catonsville Md.

Spec.—1-10-21—M&T—1500 Bks.

D 93348 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson Turner

(a) RESIDENCE No. 308 N. Pine St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliz ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Municipal Hospital Reg (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 27 1924, 19 Robert T. Harrison, Registrar

2088

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-30, 1924, to 12-23, 1924, that I last saw him alive on 12-23, 1924 and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. (History)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude F. Dunn, M. D.

12-27-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 27 1924

20 UNDERTAKER

Address

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 93349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93349

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Presbury St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius Lowback

(a) RESIDENCE No. 1706 Presbury St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	~~single~~ married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Lowback

6 DATE OF BIRTH (month, day, and year) about 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired) 1910
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Lowback

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant. Mary Weeks
(Address) 1706 Presbury St.

15 Filed ... 192 ... Registrar
Robert F. Harrison, Chief Forest Clerk.

DEC 27 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) D. T. Hennessy M. D. (Coroner.)

Dec. 26, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn. DATE OF BURIAL 12-27 1924

20 UNDERTAKER V. A. Brooks ADDRESS 1465 W. Lanvale St.

TION is very important See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93350 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93350

CERTIFICATE OF DEATH. 31

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2731 Hampden St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Palma Fischer

(a) Residence No. 2731 Hampden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Fischer

6-DATE OF BIRTH (month, day and year) March 22 1901

7-AGE. 23 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Louis Faber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Utley

12-MAIDEN NAME OF MOTHER Rachel Shine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Utley

14- (Informant) Louis Fischer

(Address) 2731 Hampden st

15- Filed 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26/924

17- I HEREBY CERTIFY, That I attended deceased from 12/5/24, 19.., to 12/26/24, 19.., that I last saw h.. alive on 12/26/24, 19.., and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows:

Lesthemia

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pub Th.

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Harrison M. D.

12/26/24 (Address) 302 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL. Dec 29. 1924

20-UNDERTAKER. John F Denny — ADDRESS 715 Lig ht St

In plain terms, so that it may be properly classified, instructions on back of certificates.

C 71924

Burial Permit Clerk

Spec.—1-10-21 - M&T - 1500 Blks.

D 93351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93351

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3521 Sweetair St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel W Switzer

(a) RESIDENCE No. 3521 Sweetair St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Noma Switzer

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 59; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plaster

(b) General nature of industry, business, or establishment in which employed (or employer): 051

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Bessie Switzer

(Address) 3521 Sweetair St

15 Filed DEC 27 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1924, to Dec. 25, 1924, that I last saw h[illegible] alive on Dec. 24, 1924, and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

(Signed) C. T. Camalier, M. D.

12-28, 1924 (Address) 3101 Kelway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md — DATE OF BURIAL: Dec 28 1924

20 UNDERTAKER: Chenowith Son — ADDRESS: 3617 Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93352

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Hudson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Michaline Wesolowski

(a) RESIDENCE NO. 2625 Hudson St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walenty Wesolowski

6 DATE OF BIRTH (month, day, and year) June 24, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pozen, Poland
(State or country)

PARENTS

10 NAME OF FATHER Novak

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pozen Poland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Poland.
(State or country)

14 Informant Frank Wesolowski.
(Address) 2625 Hudson St

15 Filed C 27 1924, 19 Robert F. Harrison, Registrar
Daniel Pettit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 25 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct - 2, 1924, to Dec - 25 - , 1924.

that I last saw h alive on Dec - 25 - , 1924,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) carcinoma of uterus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J. Davidson, M. D.

, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Dec. 29. 1924
20 UNDERTAKER M. J. Sadowski.	ADDRESS 735 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 93353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93353

CERTIFICATE OF DEATH.

197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd. Gar. Hop ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Kent

(a) RESIDENCE NO. 615 Jasper St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl K. emp.

6 DATE OF BIRTH (month, day, and year) about 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Pearl Kemp
(Address) 203 N Pine St

15 Filed DEC 27 1924, 192 ..... Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (autopsy) inquest on the body (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (autopsy) inquest, aforesaid (autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage due to gun shot wound in Chest.

(duration) 5 hrs. mos. ds.

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 26, 1924 (Address) 2802 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cy	Dec 27 1924
20 UNDERTAKER	ADDRESS
Leonard Whaley	623 Lanvale St

Information should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93354

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93354

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Eastern Ave. & 35th Street, 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frances Damasiewicz

(a) Residence No... Eastern Ave. & 35th Street St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 4 1922

7-AGE, 2 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Walter Damasiewicz

11-BIRTHPLACE OF FATHER (city or town).... Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, Anna Nowak

13-BIRTHPLACE OF MOTHER (city or town)... Baltimore
(State or Country),

14- (Informant) Mr. Walter Damasiewicz

(Address) Eastern Ave. 35th Street

15- Filed DEC 27 1924 192..... Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25 /24

17- I HEREBY CERTIFY, That I attended deceased from 12/20, 19 2.., to 12/26, 19 25

that I last saw her alive on 12/24, 19 24,

and that death occurred, on the date stated above, at 3:15 A.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis 1

Ileo colitis

.....(Duration).....yrs.....mos. 6 .....ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia & Heart failure

.....(Duration).....yrs.....mos. 1 .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptom

(Signed) Wm. H. Hartsock, M. D.

12/26, 1924 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, Dec. 27, 19.24

20-UNDERTAKER, John B. Weber ADDRESS 1803 Bank St

In print letters, as per instructions on back of certificates.

Cor.—1-12-25—M&T—100 Blks.

D 93355

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93355

CERTIFICATE OF DEATH.

25 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Curtis Ave & Plum St. Curtis Bay. WARD)

2-FULL NAME Bartholemeus Wiflant.

(a) RESIDENCE NO. 1112 Pennington Ave. Curtis Bay. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ---mos.---ds. How long in U. S., if of foreign birth? 19 yrs. ---mos.---ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If ~~single, married~~, widowed, or divorced (write the word) ~~HUSBAND~~ of ~~WIFE~~ of Tekle Wiflant.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Lithuania.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Tillie Wiflant.(daughter)
(Address) 1112 Pennington Ave. Curtis Bay.

15 Filed DEC 27 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held on inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in the head, suicide.
(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Dec. 27, 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a.a. DATE OF BURIAL Dec 29 1924

20 UNDERTAKER John Gelbiauska ADDRESS 925 S. Paca St

N.B.—Where should be carefully supplied, so that it may be possible to obtain information should be carefully supplied, so that it may be possible to obtain information should be carefully supplied, so that it may be possible to obtain information

Spec. 1-10-21—M&T—1500 Bks.

D 93356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 135 D 93356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital.

CITY OF BALTIMORE: (No. Lombard & Greene ST.) 4 WARD)

2-FULL NAME David Ephraim Bowers

(a) RESIDENCE NO. Wallace. N.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Fannie P. Bowers.

6 DATE OF BIRTH (month, day, and year) Apr. 3. 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Wallace N.C.

PARENTS

10 NAME OF FATHER Gabriel G. Bowers.

11 BIRTHPLACE OF FATHER (city or town) Wallace (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary. ?

13 BIRTHPLACE OF MOTHER (city or town) Wallace (State or country) N.C.

14 Informant University Hosp. Records (Address)

15 Filed DEC 28 1924, ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27. 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19. 1924. to Dec 27. 1924.

that I last saw him alive on Dec 27. 1924

and that death occurred, on the date stated above, at 10.5 m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Retention + Uraemia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec 24.

Was there an autopsy? no.

What test confirmed diagnosis? Observation.

(Signed) M Lawrence, M. D.

19 (Address) University Hospital Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wallace N.C	Dec 28, 24
UNDERTAKER	ADDRESS
H. Hoitzik	1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT information is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 93357

Registered No.....

1-PLACE OF DEATH Womans Hospital

City of BALTIMORE: (No. Jno St & Lafayette ave St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ada May Prickett

(a) Residence No. Montana, Wva St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX 1. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Prickett

6-DATE OF BIRTH (month, day and year) Feb 22. 1871

7-AGE, 53 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED Housewife

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, Mr Booth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Eliza B. Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn

14- (Informant) Margaret Barkell (Daughter)

(Address) Montana, Wva

15-

Filed....., 192.....

Registrar.

In plain terms, so that it may be property classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 28. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 1924, to Dec 28, 1924

that I last saw her alive on Dec 28, 1924

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Operation for Carcinoma of stomach 6 days before death

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of Dec 22, 1924

Was there an autopsy? No

What test confirmed diagnosis? Pathological specimen

(Signed) J. Arthur York, M. D.

, 19 (Address) Womans Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem. Co. Wva	Dec 28th, 1924
20-UNDERTAKER.	**ADDRESS**
P. D. Lamb & Son	1723 W. Lafayette Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

75-00 D 93358

D 93358

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4419 Harewood Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Heimiller

(a) Residence No. 4419 Harewood Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Hester Heimiller

6-DATE OF BIRTH (month, day and year) Augu 1866

7-AGE. 58 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carriage trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. William Heimiller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Mrs Stph Heimiller

(Address) 4417 Harewood Ave

15- Filed DEC 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to Dec 26 1924

That I last saw him alive on Dec 26 1924

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis of lower extremities

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. 1 mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Duncan M. D

, 19 (Address) 5104 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cemetery

DATE OF BURIAL. Dec 29 1924

20-UNDERTAKER. Geo V. John H. Deupfler & Son

ADDRESS 801 W. Fayette St.

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto Gen. Hospital

REGISTERED NO. 936.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) Raynor ave and Dukeland ST., 16 (WARD)

2-FULL NAME Miss Emilie Roeneke

(a) RESIDENCE NO. 806 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothes fitter
(b) General nature of industry, business, or establishment in which employed (or employer) 880
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER August Roeneke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frida Borger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Schwaab.
(Address) 330 S. Calhoun St.

15 Filed ..... 19 .... Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from
12 - 21 - 1924, to Dec 26 1924.
that I last saw her alive on Dec. 26, 7:30 am., 1924.
and that death occurred, on the date stated above, at 7:45 am.
The CAUSE OF DEATH* was as follows:
cerebral hemorrhage

(duration) yrs. mos 1½ da.
CONTRIBUTORY (Secondary) gen. arteriosclerosis
(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? yes.
(Signed) Samuel Weinberg, M. D.
, 19 (Address) 2302 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec. 29, 1924

20 UNDERTAKER Mrs Mc John H. Teufel & Son ADDRESS 831 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93360

CERTIFICATE OF DEATH.

161-B 93360

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

CITY OF BALTIMORE, (No. 1 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cohen

(a) RESIDENCE NO. 1018 Patterson Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benj Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Jack Lewis (Address) Westminster Pk

15 Filed DEC 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924, to Dec 27, 1924, that I last saw him alive on Dec 27, 1924, and that death occurred, on the date stated above, at 6 40 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isidor Hirsh M. D.

Dec, 1924 (Address) Hebrew Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohrey Shalom DATE OF BURIAL 12/28 1924

20 UNDERTAKER Jack Lewis ADDRESS 1409 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of conditions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93361

90

D 93361

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Silberg

(a) RESIDENCE NO. 109 S. Chester ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct — 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer) Factory 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Meyer Silberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Meyer Silberg
(Address) 1061 N Caltbert St

15 Filed DEC 28 1924 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 ....., 1924, to Dec. 27, 1924, that I last saw h.. alive on Dec. 27, 1924, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure & dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chr. Mitral stenosis & insufficiency aortic insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic & Lab.

(Signed) Isidor J. Fry M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem. DATE OF BURIAL 12/28/24

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

Kistner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93362

D 93362

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1637 Harford Ave. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kistner

(a) Residence No. 1637 Harford Ave. St., 9 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-~~Single~~ Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Kistner

6-DATE OF BIRTH (month, day and year) Feb 3 1856 or 8-1856

7-AGE. 68 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Herman Kostens

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Catherine Kostens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) W. T. Adkinson

Address 1607 Harford ave

15- [illegible] ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1924 to Dec 25 1924

that I last saw h[illegible] alive on Dec 25 1924

and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

12/26/24 (Address) 1302 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	Dec 28 1924
20-UNDERTAKER.	ADDRESS
Geo L. Rush	1735 Harford Av.

In plain terms, so that it may be properly read. Follow instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93363

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4726 Pimlico Road 27 WARD)

2-FULL NAME Henry J. Rose

(a) RESIDENCE No. 4726 Pimlico Road WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia M

6 DATE OF BIRTH (month, day, and year): Jan 8. 1844

7 AGE: Years 80 | Months 11 | Days 19 | If LESS than 1 day,... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hoffman

886

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Francis Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Klee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Henry Rose

(Address): 4726 Pimlico Rd

15 Filed ... 19 ... Registrar

DEC 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924, to Dec 26, 1924, that I last saw him alive on Dec 23, 1924, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwards J Wells, M. D.

, 19 (Address) 2 W Biddle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Dec. 29 1924

DATE OF BURIAL

20 UNDERTAKER: H. M. Cook

ADDRESS: 502 E. Lee.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93364

CERTIFICATE OF DEATH.

31

Registered No. D 93364

1-PLACE OF DEATH

City of BALTIMORE. (No. 3713 Rail Road Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A. Long

(a) Residence No. 3713 Rail Road Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ John W. Long

6-DATE OF BIRTH (month, day and year) Feb 3 1859

7-AGE. 65 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Chas. B. LeBon

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Catherine Kailer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mr. A E Long

(Address) 3713 Rail Road Av

15-

Filed ... 192...

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1924 to Dec 26 1924, that I last saw her alive on Dec 26 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 7 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine Exam.

(Signed) Wm. H. Hedemann, M. D.

, 19 (Address) 850 E 36 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cemetery DATE OF BURIAL, Dec 29, 1924

20-UNDERTAKER. A D Marshall ADDRESS 3539 Falls Rd

In plain terms, so that it may be properly typed. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93365

CERTIFICATE OF DEATH.

188-903 D 93365

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew J. Hartman

(a) RESIDENCE NO 1909 Ellwood Place(North) ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) August 3/1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Rubber Roofing Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Annie Harker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Andrew Hartman
(Address) 1909 Ellwood Place (N)

15 Filed DEC 28 1924, 192 ROBERT R. [illegible] Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/24 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull (Automobile Accident

(Inquest Dec 29/24)

(duration) ..... yrs. ..... mos ..... ds.

*CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Walker, M. D. (Coroner.)

12/27/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Dec 29 1924

20 UNDERTAKER Veney Undertaking Co — ADDRESS 1501 E Eager

Spec. 12-2-24-5M-B.R.S.—400 Bks.

D 33366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D 33366

1-PLACE OF DEATH
City of BALTIMORE: (No. 911 Bond St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Dent

(a) Residence No. 911 Bond St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Dent

6-DATE OF BIRTH (month, day and year) 1875

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ry Co
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Manuel Dent

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Teresa Blair

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Theresa Dent
(Address) 911 Bond St

15- Filed Dec 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 24/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 19 24, to Dec 24 19 24
that I last saw h alive on Dec 23 19 24
and that death occurred, on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage 1
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Thos Scott Fenton, M. D.
Dec 26, 1924 (Address) 939 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 28 1924

20-UNDERTAKER, Samuel S Brantley ADDRESS 378 N Eutaw St

DEC 26 1924 ROBERT N. KNOX Burial Permit Clerk.

In plain terms, as directed by instructions on back of certificates.

Spec—12-23-24—E.B.R.S.—400 Bks.

Selicked.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93367 Yes

CERTIFICATE OF DEATH.

179 D 93367

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Arbutus Ave (Lakeland) St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Creamer

(a) Residence No. Arbutus Ave (Lakeland) St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Creamer.

6-DATE OF BIRTH (month, day and year) July 2 1859

7-AGE, 65 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

040

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph Creamer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Catherine Bowers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Margaret Creamer

(Address) Lakeland-Md

15- Filed ..... 192.....

Register

In plain terms, so that it may be understood. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 24 to Dec 25, 19 24

that I last saw him alive on Dec 20, 19 24

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Appendicitis

(Duration) ? yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Urine & Autopsy

(Signed) W. Brumm, M. D.

, 19 (Address) 1013 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Cross. A.A.Co.	12-29-1924
20-UNDERTAKER	ADDRESS
McJames Degnan Son	1000 Race St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93368

CERTIFICATE OF DEATH.

Registered No. 98

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 Cereal Street Curtis Bay St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus. Ulatowski

(a) Residence No. 15 Cereal Street Curtis Bay St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 11 1921

7-AGE. 3 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Aleksander . Ulatowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Poland

12-MAIDEN NAME OF MOTHER Eva. Kloszewska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Poland

14- (Informant) Mr Aleksander. Ulatowski

(Address) 15 Cersal Street

DEC 28 1924

Filed 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 27/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27 1924 to Dec. 27 1924

that I last saw him alive on Dec. 27 1924

and that death occurred, on the date stated above, at 6 50 p.m.

The CAUSE OF DEATH* was as follows:

Laryngismus Stridulus

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Rachitis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & Laboratory

(Signed) N. Blount M. D.

12/28 1924 (Address) 2350 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross A.A.Co. DATE OF BURIAL. Dec. 29, 1924

20-UNDERTAKER. John M Weber ADDRESS 1803 Banks St

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospitals ost. B 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Katz

(a) Residence No. 24 South High St. St. Baltimore Md. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write Word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jacob Greenspan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Mrs. Sophia Greenspan Nolon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) A. L. Katz

(Address) 24 S. High St.

15- Filed DEC 28 1924 ROBERT R. KRAUTER, Registrar. Vital Records Clerk.

In plain terms, so that it may be properly coded, instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from 12/19 1924 to 12/27 1924

that I last saw her alive on 12/27 1924

and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (surgical operation)

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of several years ago

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical

(Signed) Ira P. Plamp M. D.

12/28, 1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 12/28 1924

20-UNDERTAKER, Sol Kurison & Bro — ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93370

101-00 D 93370 ✓

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Davis

(a) RESIDENCE NO. 825 Ensor Street ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work and

(b) General nature of industry, business, or establishment in which employed (or employer) Fitter

(c) Name of employer Dixon Bartlett Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Mr. John T. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Miss Ann Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Annie Davis
(Address) 825 Ensor St.

15 Filed DEC 28 1924 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1924, to Dec. 26, 1924, that I last saw her alive on Dec. 26, 1924, and that death occurred, on the date stated above, at 3:40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) abt. 2 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Tom Talbot M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 29 1924

20 UNDERTAKER Robt J Turner Sons

ADDRESS 1442 N Broadway

ROBERT R. BRADLEY
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly Classified. Particular attention is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93371

CERTIFICATE OF DEATH.

47 D 93371

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Montford ave ST., 8 WARD)

2-FULL NAME Elizebeth Kolb

(a) RESIDENCE No. 1311 Montford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Kolb

6 DATE OF BIRTH (month, day, and year): Feb 22 1871

7 AGE: Years 53 years; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo Stegman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Keahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jos Stegman
(Address): 1311 N Montford ave

15 Filed ..... 19..... Registrar

DEC 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1924, to Dec 26, 1924, that I last saw h[illegible] alive on Dec 25 24 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

I Carcinoma of Throat.
Carcinoma of Stomach
Cardiac (duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) ... yrs. 5 mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of Sept 24

Was there an autopsy? No

What test confirmed diagnosis? Sym dia

(Signed) [illegible] M. D.

1924 (Address) 600 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemty — DATE OF BURIAL: Dec 29 1924

20 UNDERTAKER: Robt J Turner Sons — ADDRESS: 1512 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93372

CERTIFICATE OF DEATH.

D 93372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 N. Mount ST. 15 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Love

(a) RESIDENCE. NO. 1529 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Love.

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer Mrs. Brooks

9 BIRTHPLACE (city or town) (State or country) Arlington, Md.

PARENTS

10 NAME OF FATHER Saml. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rebecca Smith
(Address) 1529 N. Mount St.

15 Filed DEC 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1924, to Dec. 25, 1924, that I last saw he alive on Dec. 25, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) John D. Quinn, M. D.

12/27, 1924 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 28 1924
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93373

CERTIFICATE OF DEATH.

47 D 93373

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S. Exeter ST.: B WARD)

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Bacogalupa

(a) RESIDENCE. No. 406 S. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 22-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Flesenger Co

9 BIRTHPLACE (city or town) (State or country) ~~Italy~~ Baltimore

PARENTS

10 NAME OF FATHER Andrew Bacogalupi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carlina Cuneo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Teresa Bacogalupi

(Address) 406 S Exeter St

15 Filed ... 19 ... Registrar

DEC 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 ... 19 23 ... to Dec. 26 ... 19 24

that I last saw h alive on Dec. 26 19 24

and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Uncertified Scarlatina

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 2-1923

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C F Compton, M. D.

12-27 19 24 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL St Vincent

DATE OF BURIAL Dec 30 1924

20 UNDERTAKER Kendall Dyer & Son

ADDRESS 978 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S. A. FEB 1924

Spec.—1-10-21—M&T—1500 Blks.

D 93374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93374

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Glenn & Rasburg ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Martel

(a) RESIDENCE NO. Glenn & Rasburg ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 00 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Martel

6 DATE OF BIRTH (month, day, and year) June 24 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conderlaus Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorthey Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Joseph Martel Glenn & Rasburg ave

Filed DEC 26 1924 Registrar

ROBERT R. KEMP Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1924, to Dec 26, 1924, that I last saw h alive on Dec 25th, 1924, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Edw A Stenson, M. D.

Dec 28 1924 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 29 1924

20 UNDERTAKER Wendell Ryppel & Son — ADDRESS 37 S Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

DARK

Spec—12-23-21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 93375

Registered No.....

93375

1-PLACE OF DEATH

City of BALTIMORE: (No. 1006 S. Potomac St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Jaworzewska

(a) Residence No. 1006 S. Potomac St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year)

7-AGE: 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Jacob Bialch

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant): Jacob Krzesuski

(Address): 1006 S. Potomac St.

15- Filed DEC 28 1924 ROBERT R. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 26-24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23rd, 1924, to Dec. 26th, 1924, that I last saw her alive on Dec. 25th, 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Left Hemiplegia

(Signed) F. Rolinski M. D., M. D.

, 19 (Address) 2274 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Baltimore Md.

DATE OF BURIAL, 12/29/24, 19..

20-UNDERTAKER, Stephen Zalkowski

ADDRESS 1003 E. Fremont Ave

instructions on back of certificates.

Burial Permit Issued

Cor.—1-12-23—M&T—100 Blks.

D 93376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93376

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 Potomac Ave. Brooklyn ST., 25 WARD)

2-FULL NAME Raymond R. Potee.

(a) RESIDENCE NO. 538 Potomac Ave. Brooklyn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred --- yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 11, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	---	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Leon T. Potee.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Laura E. Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Laura E. Potee. (mother)
(Address) 538 Potomac Ave. Brooklyn.

15 Filed DEC 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 27, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.

Dec, 27th 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Dec 29 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Light

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93377

CERTIFICATE OF DEATH.

12 129

D 93377
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brandon

(a) Residence No. 328 E 23rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1883

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Nathaniel Rogers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Susan Bailey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Municipal Hospital Records

(Address)

15- Filed DEC 29 1924 EVELYN R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-26-24

17- I HEREBY CERTIFY, That I attended deceased from 12-23, 1924, to 12-26, 1924, that I last saw him alive on 12-25, 1924, and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Hypertension

Chronic Nephritis

(Duration) 1 yrs. (Uncertain) mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Brand, M. D.

12-26, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel MT	Dec 29 1924
20-UNDERTAKER,	ADDRESS
J. H. Brown & Son	108 W Monument St

In plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93378

CERTIFICATE OF DEATH.

74-001

D 93378

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Mallory

(a) RESIDENCE NO. 1401 Madison Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	7-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Framingham / Mass.

PARENTS

10 NAME OF FATHER: John H. Gunner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga.

12 MAIDEN NAME OF MOTHER: Cecelia Barbolt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Nebraska Co. Ire.

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27- 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26- 1924, to Dec 27- 1924, that I last saw her alive on Dec 27- 1924, and that death occurred, on the date stated above, at 4.50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 hrs ds.

CONTRIBUTORY (Secondary) Chr. Nephritis - Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Hemorrhage at base of brain

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 29 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Co	Oakland Md. Co. Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 93379

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 William St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kane

(a) Residence No. 819 William St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Kane

6-DATE OF BIRTH (month, day and year): 1850

7-AGE: 74 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Lawrence Corbett

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

11- (Informant): Ella Kane

(Address): 819 William st

13-

Filed DEC 29 1924 192.... ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

In plain terms, so that it may be properly understood, write instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12.26.24

17- I HEREBY CERTIFY, That I attended deceased from 12.15. 1924, to 12.26. 1924, that I last saw h.. alive on 12.26. 1924, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis
Chronic Nephritis
Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia
(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Symptomatology

(Signed) Francis Dade M. D.
12. 29. 1924 (Address) 107 Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec 29 1924
20-UNDERTAKER	**ADDRESS**
F. E. Kramer & Son	703 Hanover

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93380

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93380

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 23 N. Bradford St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Francis Behrens

(a) Residence No. 23 N. Bradford St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) October 9 1924

If LESS than 1 day, ...hrs. or....min.?

7-AGE. ....yrs. 2 mos. 18 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Behrens

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Pearl Sparr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant)..... John Behrens

(Address)..... 23 N. Bradford St

15- Filed DEC 29 1924 ROBERT R. KRAUTER Registrar.

Rapid Print

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1924 to Dec 27 1924

that I last saw him alive on Dec 27 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) .....yrs. 3 mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Caleb N Athey M. D.

Dec 28 1924 (Address) 100 S Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel DATE OF BURIAL. Dec 29 1924

20-UNDERTAKER. Kendall Hopper & Son ADDRESS 374 Lombard

In plain terms, so that it may be properly understood. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93381

CERTIFICATE OF DEATH.

90

REGISTERED NO. D 93381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas C. Hill

(a) RESIDENCE NO 2324 Orleans St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary M. Hill

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Ind
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Charles Hill
(Address): 2324 Orleans St.

15 Filed DEC 29 1924 ROBERT R. KING Registrar
Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or Inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

a few hours (duration)

CONTRIBUTORY (Secondary) Duration yrs. mos. ds.

(duration) yrs. mos. ds.

(Signed) T. F. Grealy, M. D. (Coroner.)

12-29- 1924 (Address) 1711 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Dec 28 1924

20 UNDERTAKER: Wendell Diffel & Son — ADDRESS: 575 S. Arch St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93382

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David Lee Maulsby

(a) Residence No. 105 Roland Ave. St., Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? 51 yrs. 1 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND ~~of~~ ~~WIFE~~ of Mrs. O. L. Maulsby

6-DATE OF BIRTH (month, day and year) Nov. 1, 1873

7-AGE.	If LESS than 1 day.
51 yrs. 1 mos. 27 ds.	....hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, O. Lee Maulsby

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary George

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs Maud F. Maulsby (wife)

(Address) Roland Park - City

15- Filed DEC 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 27/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1924 to Dec 27, 1924 that I last saw him alive on Dec 27, 1924 and that death occurred, on the date stated above, at 8:23 A.m.

The CAUSE OF DEATH* was as follows:

Amyloidosis

Chronic Nephritis

Myocardial insufficiency (Duration) 1 yr. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic osteomyelitis (Duration) 37 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Edwin P. Jarrell, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Dec 28/1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 93383 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 93383

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 625 E 34th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry H. Schroeder

(a) Residence No. 625 E. 34th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Martha J. Schroeder

6-DATE OF BIRTH (month, day and year) Jan. 13th 1856

7-AGE. 68 yrs. 11 mos. 14 ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). 015
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Casper H. Schroeder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbra Hoddinott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14-
(Informant) Henry H. Schroeder
(Address) 625 E 34th St

15-
Filed DEC 9 1924 19.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 27th 24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28 19 24 to Dec 27 19 24
that I last saw h~~im~~ alive on Dec 27 19 24
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Uremia with
Hypertension

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 25/24

Was there an autopsy? no

What test confirmed diagnosis? Clin & Chem. Lab.

(Signed) Geo B Tyler M. D
19 (Address) St Joseph Hosp.

*State the **Disease Causing Death**, or if deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery — DATE OF BURIAL. Dec 31st 1924

20-UNDERTAKER, George Schilling & Sons — ADDRESS 1126 E Monument st

In plain terms, so that it may be properly coded. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 93384

HEALTH DEPARTMENT—CITY OF BALTIMORE

X10 D 93384

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Parks

(a) RESIDENCE NO. Brooklyn Balto Co. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Parks

6 DATE OF BIRTH (month, day, and year) June, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Isaac Emerson

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER John T. D. Parks

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Catherine Musgrove

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. May Parker

(Address) 1036 Falls Rd

15 Filed DEC 29 1924 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1924.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1924, to Dec 27, 1924.

that I last saw him alive on Dec 27, 1924.

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? O. E. K. W. Gelby

(Signed) H F Borgandt M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mays Chapel Baltimore

DATE OF BURIAL Dec 29, 1924

20 UNDERTAKER E Le Roy Stifflen

ADDRESS 125 E. North Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93385

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 34 E. 27th. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Williams

(a) Residence No. 34 E. 27th St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6-DATE OF BIRTH (month, day and year) Oct. 27 1864

7-AGE, 60 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) Hecht Bros.

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Williams

11-BIRTHPLACE OF FATHER (city or town) Wales
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Thomas

13-BIRTHPLACE OF MOTHER (city or town) Wales
(State or Country),

14- (Informant) Dr. A.L. Fehsenfeld

(Address) 2806 Garrison Avenue

15- Filed ..... 192 RUSSELL R. KRAUTER Registrar.

DEC 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 25/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 19 24 to Dec 25 19 24

that I last saw h[illegible] alive on Dec 25 19 24

and that death occurred, on the date stated above, at 11 00 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ..... yrs. ..... mos. " ..... ds.

CONTRIBUTORY (Secondary) Infection - Gallbladder side of face (Duration) ..... yrs. ..... mos. 17 ds.

18-Where was disease contracted if not at place of death? 34 E. 27th St. Hospital

Did an operation precede death? ..... Date of Dec 12, 24

Was there an autopsy? No

What test confirmed diagnosis? All at our hospital

(Signed) Herbert M. Foster, M. D.

, 19 (Address) 924 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. 12/29 19 24

20-UNDERTAKER. Henry W. Spears & Son

ADDRESS 805 N. Calvert St.

In plain terms, so that every one can understand, instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93386

CERTIFICATE OF DEATH.

14 74-801 D 93386

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1824 Bolton St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry S. Rayner

(a) Residence No. 1824 Bolton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. -- mos. -- ds. -- How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Johnetta Bartholow

6-DATE OF BIRTH (month, day and year) Feb. 4, 1860

7-AGE.	If LESS than 1 day,
64 yrs. 10 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: District Manager (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer): Security Lime and Cement Co.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Philadelphia Pa.

PARENTS.

10-NAME OF FATHER: Joseph Rayner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Jane Ward

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): England

11- (Informant): Mrs. Johnetta N. Rayner

(Address): 1824 Bolton St.

15- Filed 12/29, 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 26. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1924 to Dec. 25, 1924, that I last saw h.m alive on Dec. 25, 1924, and that death occurred, on the date stated above, at 5-45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-Sclerosis

Left Cerebral Hemorrhage

Interstitial Nephritis

(Duration) 3 yrs. 1 mos. +21 ds.

CONTRIBUTORY (Secondary) Uremic Coma

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis &c

(Signed) M. J. Porter, M. D.

12/26, 1924 (Address) 721 Eutaw Cor Richard Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Green Mount Cemetery	12/29, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Myers & Son	805 N. Calvert

In placing entries on this certificate, follow instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

93387 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93387

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 649 W Lafayette St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Emma Jane Lyle

(a) Residence No. 649 W Lafayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-[redacted] widowed, [redacted] (Write the word.) Widowed

5a-If married, widowed, [redacted] of (or) WIFE of Sanford Lyle

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Brownsburg VA

PARENTS.

10-NAME OF FATHER. Isaac Lewis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Malinda Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14-(Informant) Malinda Washington

(Address).... 649 Lafayette Ave

15-[redacted]

DEC 29 1924 ROBERT E. KRAUSE Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 23 1924

17- I HEREBY CERTIFY, That I attended deceased from March 24 to Dec 23 1924

(but I last saw h[redacted] alive on Dec 23 1924

and that death occurred, on the date stated above, at 1 1/2 a m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Claude M. D

Dec 26, 1924 (Address) 15 W Mulberry

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn cemetery

DATE OF BURIAL. Dec. 29 1924

20-UNDERTAKER. Mrs Chas. H. Dennis and F E Kelson

ADDRESS 1303 Freestman St

In print letters, so that it may be legible. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 93388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93388

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. Ernst.

(a) RESIDENCE NO. 1312 Hillman St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, HUSBAND of XXXXXXXXXXXX XXX XXXXX Catherine Ernst.

6 DATE OF BIRTH (month, day, and year) November 3, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Hard wood finisher.
(b) General nature of industry, business, or establishment in which employed (or employer): 014
(c) Name of employer: F.X. Ganter.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Ernst.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louise Fahle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine Ernst. (wife)
(Address) 1312 Hillman St.

15 DEC 29 1924 ROBERT P. KRAMER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 26, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Apnoea.

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.

Dec. 28, 1924 (Address) 1017 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westgate Cemetery	Dec 29 192 4
UNDERTAKER	ADDRESS
F.O. Kuppert	1850 W. Balto St

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93389

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 7120 E Lombard St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lena Amelia Clay,

(a) Residence No. 7140 E Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John E Clay.

6-DATE OF BIRTH (month, day and year) Nov 15 1863

7-AGE, 61 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, —? Hass

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)..Edwin J. Clay.....

(Address)...1123 N Carrollton Ave

15- Filed....., 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

DEC 29 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/27/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Dec 27, 1924, that I last saw h.. alive on Dec 26, 1924 and that death occurred, on the date stated above, at 0-9-0 a.m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(Duration)..... yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonal Heart Disease

(Duration)..... yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Dearen, M. D.

1/28, 1924 (Address) 3901 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem	Dec 29, 1924
20-UNDERTAKER.	ADDRESS.
John Sellrich	2008 Aisquith

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93390 X 57 D 93390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Altamont ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Herbert Wesley Wheeler

(a) RESIDENCE NO. Hotel Altamont ST., Entaw Pl. & Lanvale St WARD Rochester N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Mrs Mary Miller Wheeler

6 DATE OF BIRTH (month, day, and year): Feb 19. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stock Broker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Princeton Mass.

PARENTS

10 NAME OF FATHER: Wesley Wheeler.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Mary Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass.

14 Informant (Address): Mary Miller Wheeler. Rochester New York

15 Filed DEC 29 1924 ROBERT R. KRAFFT, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1924. to Dec 27 1924 that I last saw him alive on Dec. 27, 1924 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Pyelitis - bilateral

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Laboratory

(Signed) Grant Ward, M. D.

, 19 (Address) 1418 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rochester New York — DATE OF BURIAL: Dec 29 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 712 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2100 E. Biddle St., 8 Ward) 76

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie M. Ahles

(a) Residence No. 2100 E. Biddle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Ahles

6-DATE OF BIRTH (month, day and year) Mar 10"

7-AGE. 40 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. W. Lyons.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Mahoney.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Jos. Ahles

(Address) 2100 E Biddle St

15- (Filed) DEC 29 1924 ROSSEL S. KRAUTER, Registrar.

in plain terms, so that it may be properly classified. instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 25/24

17- I HEREBY CERTIFY, That I attended deceased from March 20 1924 to Dec 23 1924

that I last saw her alive on Dec 23 1924

and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

& Paralysis of Heart

put Prior to that genuall

Paresis (Duration) one Mos. yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death? at her home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. J. Dorsey M. D.

, 19 (Address) 1613 W Mulberry

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 12/29/24 19
20-UNDERTAKER. Geo M. Finis & Son	ADDRESS 811 N Wolfe St

Spec—12-23-21—E.B.R.S.—400 Blks.

Lake Drive near Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93392

D 93392

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Lake Drive Apts. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Boten

(a) Residence No. Lake Drive Apts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced.
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Adolph Boten

6-DATE OF BIRTH (month, day and year) May 7 1883

7-AGE. 41 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER Louis L. Walter

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Lieblick

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Mr. Adolph Boten

(Address) Lake Drive Apts

15-

Filed ..... 192.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from March 14, 1924 to Dec 27, 1924

that I last saw her alive on Dec 27, 1924

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Secondary to

Carcinoma of Colon *

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Anaemia; Pulmonary Metastasis

(Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of * Nov. 24 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathologic Exam. of resected colon

(Signed) Louis P. Hamburger M. D.

Dec 28, 1924 (Address) 120 E. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Balto. Hebrew Cem.	12/29/ 1924
20-UNDERTAKER. David Sondheim	ADDRESS 118-20 W. Mt. Royal Ave

instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Ewing

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93393

+ 179 D 93393

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Dorothy Ewing

(a) RESIDENCE No Emerson Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

8a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2		4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Oscar Ewing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Sarah J. Sadler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md

14 Informant Oscar Ewing (Address) Bel Air Md.

15 Filed DEC 29 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ ..... ~~or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body Accidentally
Fell into a tub of hot water

(duration) ..... yrs. a few hrs. mos ..... ds.

CONTRIBUTORY (Secondary) Accident

(duration) ..... yrs. ..... mos ..... ds.

(Signed) H K Granuel, M. D.
(Coroner)

12, 29, 192 (Address) 1137 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dublin M. E. Cemetery — DATE OF BURIAL Dec 31 1924

20 UNDERTAKER Chas. E. Hamburger — ADDRESS Fallston Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 93394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 16 X 188 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Raymond Allender

(Residence in Baltimore: No. 1606 W. Lanvale Street St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. April 12th, 1901
(Month) (Day) (Year)

7-AGE. 23 yrs. 8 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Line Man
(b) General nature of industry, business, or establishment in which employed (or employer): United Railroad

9-BIRTHPLACE, (State or Country). Glyndon, Maryland

PARENTS.

10-NAME OF FATHER. Edward Allender

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Maud

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Blanche A. Allender
(Address) 1606 W. Lanvale Street

15-
Filed ..... 192 .....
Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 27th 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries received in Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

12-27-24 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glyndon Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
All Saints Cem Woodlawn	Dec 30 1924

20-UNDERTAKER.	ADDRESS
Joseph B Cox	1003 N. Calvert St

Be very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93395 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93395

* CERTIFICATE OF DEATH. 15 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 3807 Chatham Road (St.) (Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Gosnell

(a) RESIDENCE. No. 3807 Chatham Rd St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Upton S. Gosnell

6 DATE OF BIRTH (month, day, and year) July 26, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Ledley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Mills

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant John T. Owens
(Address) 3807 Chatham Road

15 Filed ..... 19..... ROBERT R. KRAUTZ Registrar

DEC 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 27/Dec 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1924 to Dec. 27, 1924.

that I last saw her alive on Dec. 1, 1924.

and that death occurred, on the date stated above, at 11:50 A.m.

The CAUSE OF DEATH* was as follows:

Cardio-Sclerosis (Senile)
Myocardial degeneration.

about (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia, old age toxaemia (bed sore) (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? examination

(Signed) Carlos I. Taggart, M. D.

12-29-24 (Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 30 1924
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93396

CERTIFICATE OF DEATH.

46D 93396

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 William ST. 24 WARD)

2-FULL NAME Ella V. Burkert.

(a) RESIDENCE NO. 1133 William ST., 24 WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Leonard J. Burkert.

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER [illegible] Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Leonard J. Burkert.
(Address) 1133 William St.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to Dec 26 1924
that I last saw h[illegible] alive on Dec 26 1924
and that death occurred, on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Cardiac Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Uremic Convulsions
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of May 1924
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [illegible] M. D.
12 27 1924 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL 12 29 1924

20 UNDERTAKER [illegible] Sons | ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

1924
63

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93397

CERTIFICATE OF DEATH.

17 D 93397

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hosp. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pierson

(a) Residence No. 1429 Riggs Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Cecelia Pierson

6-DATE OF BIRTH (month, day and year) Dec 1861

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Adeline Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Cecelia Pierson

(Address) 1429 Riggs Ave

15-

Filed DEC 29 1924 Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-27-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1924 to Dec 27 1924

that I last saw him alive on Dec 27 1924

and that death occurred, on the date stated above, at 6 00 A. P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Pulmonary Edema

Myo & endo cardiitis Arterio-Sclerosis & hypertension (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

Gangrene (Duration) (foot) mos. 7 wks.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. St. Josephs Hosp., M. D

(Address) 1 Gilbert Ave E.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral	Dec 30 1924
20-UNDERTAKER,	ADDRESS
Lammes & Wright	864 Mary

In plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.) 3502 E. Pratt St., 46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Greason

(a) Residence No. 3502 E Pratt St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Thos. D. Greason

6-DATE OF BIRTH (month, day and year) Feb 7/71

7-AGE. 53 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER, Jacob Englehardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Thos. D. Greason

(Address) 3502 E. Pratt St.

15-

Filed ..... 192..... ROBERT P. KRAUTH Registrar.

Burial Permit Issued

In plain terms, so that it may be properly transcribed, state the cause of death. Do not use abbreviations or technical terms. Follow instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from October 15 1924 to December 27 1924

That I last saw h.. alive on Dec 26 1924

and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(Duration) yrs. 2/12 mos. ds. To my knowledge

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N Athey M. D

Dec 28 1924 (Address) 100 S. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn	12/30 1924
20-UNDERTAKER.	ADDRESS.
Philip Herwig	2016 Orleans St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93399

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

D 93399
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 111 S. Potomac St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. George Dressel

(a) Residence No. 111 S. Potomac St., Ward
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Fredericka Dressel

6-DATE OF BIRTH (month, day and year) Aug 4/33

7-AGE. 64 yrs. 4 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 003

(b) General nature of industry, business, or establishment in which employed (or employer) Baker

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo. Dressel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ger.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) George Dressel

(Address) 111 S. Potomac

15- Filed DEC 28 1924 ROBERT R. KRAUSE Registrar.

Burial Permit Issued

In plain terms, so that it may be properly coded. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 19 24 to Dec 27 19 24

that I last saw h[illegible] alive on Dec 27 19

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Infirmities Nephritis

(Duration) yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Knox Insley, M. D.

Dec 28. 19 24 (Address) 2938 E. Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL, 12/31 19 24

20-UNDERTAKER, Philip Henry — ADDRESS 2016 Aliceanna

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93400

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 812 N. Pat. Pk. Ave St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Klueber

(a) Residence No. 812 N. Pat. Pk. Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Leo. Klueber

6-DATE OF BIRTH (month, day and year) Sept 3/56

7-AGE. 68 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer .....

9-BIRTHPLACE (city or town). (State or Country). City

PARENTS.

10-NAME OF FATHER. John F. Degele

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Sophia E.

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Md.

14- (Informant) Iris Degele

(Address) 812 N. Pat. Pk. Ave

15- ROBERT F. KNOTT

Filed ..... 192 ..... Burial Permit Clerk. Registrar.

DEC 29 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1924 to Dec 27 1924

that I last saw h.. alive on Dec 27 1924

and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alf. Legg M. D

12/29 1924 (Address) 709 E. Bway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Schwartz — DATE OF BURIAL. 12/30 1924

20-UNDERTAKER. Philip Herwig — ADDRESS 2016 Aliceanna

In plain words, so that every one may understand, give full instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 93401 — 101-801 — D 93401

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Grahm

(a) Residence No. 1039 Fleetwood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed,~~ or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James E. Grahm

6-DATE OF BIRTH (month, day and year) 1885

7-AGE 39. yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank McBride

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Marie O'Kafe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna.

11- (Informant) Bay View Hospital

(Address) Balto, Md.

15- Filed DEC 29 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1924 to Dec. 26 1924

that I last saw her alive on Dec. 26 1924

and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Dipsomania

Poly Cystic Kidneys, Marie Bone (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Feldsmith M.D.

12/27/1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Dec 30 1924

20-UNDERTAKER, H. C. Windefeld — ADDRESS Guy Fremont Ave

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93402 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 E. Madison St. 10 Ward) Registered No. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Bridget McShane

(a) Residence No. 600 E. Madison St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edward McShane

6-DATE OF BIRTH (month, day and year) Mar 1864

7-AGE, 60 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Work

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Donnelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah McKeon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Margaret Donnelly

(Address) 204 Robb St

15- Filed ..... 19.. RUPERT R. ...
Registrar.

DEC 29 1924 Burial Permit Clerk.

In plain words, so that it may be properly classified. Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-27-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 24, 1924, to Dec 26, 1924

that I last saw h... alive on Dec 26, 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

12-27, 1924 (Address) 732 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral

DATE OF BURIAL, Dec 30, 1924

20-UNDERTAKER, H. C. Wiedefeld

ADDRESS 914 Fremont Av

Spec—12-23-21—E.B.R.S.—400 Bks.

Norman

D 93403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 93403

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 13-E Lanvale St., 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Arthur Augusta Norman

(a) Residence No. 136 Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida E Norman

6-DATE OF BIRTH (month, day and year) Nov 15-1874

7-AGE. 50 yrs. 1 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work R. R Express

(b) General nature of industry, business, or establishment in which employed (or employer) Messenger

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER Charles E Norman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Augusta Woods

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Mrs Ida E Norman

(Address) 136 Lanvale

15- Filed, DEC 29 1924 ROBERT R. KRAUTER, Burial Permit Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 27 1924.

17- I HEREBY CERTIFY, That I attended deceased from Nov 4th 1924 to Dec. 27 1924

that I last saw h[illegible] alive on Dec 27th 1924

and that death occurred, on the date stated above, at 7.05 a m.

The CAUSE OF DEATH* was as follows:

Arterial embolism

(Duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

Myocarditis (Duration) yrs. mos. (2) 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None except Exam.

(Signed) Edward L Johnson M. D.

, 19 (Address) 712 St Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Howard Harmony Cem. Ex'rd — DATE OF BURIAL. Dec 29 19 24

20-UNDERTAKER. W J Pedersen Sons — ADDRESS North Ave

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93404 31 D 93404

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Ettinger St., 17 WARD)

2-FULL NAME William Clark

(a) RESIDENCE NO. 1309 Ettinger St., ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Clark

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Hezekiah Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Warren Clark
(Address) 1309 Ettinger St.

15 Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 28, 1924 (Address) 100 Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St John, Govans Md

DATE OF BURIAL Dec 30 1924

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Druid Hill Ave

TION is very important See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93405

90 D 93405

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 E. 23 ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W. Jackson

(a) RESIDENCE No. 311 E. 23 ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 55.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: "

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Wm. W. Gross (Address) 311 W. 23rd St.

15 Filed ..., 192... ROBERT J. KRAUTER, Registrar

Burial Permit Clerk.

TION is very important See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease

Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D. (Coroner.)

Dec 27, 1924 (Address) 3692 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem.

DATE OF BURIAL: Dec. 29 1924

20 UNDERTAKER: Joseph A Farrell

ADDRESS 2319 Dundalk 20

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93406

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

93406.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2140 Druid Hill ST., 14 WARD)

2-FULL NAME James H. Harrell

(a) RESIDENCE NO. 2140 Druid Hill ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ella Harrell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant Mrs. Ella Harrell
(Address) 2140 Druid Hill ave

15 Filed DEC 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-25 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec-20- 1924 to Dec-25- 1924.

that I last saw him alive on Dec-25- 1924,

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

Dec 1924 (Address) 3039 Mc Culloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mitchell N.C.

DATE OF BURIAL Dec. 1924

ADDRESS 2919 Druid

20 UNDERTAKER Joseph A Farrell

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93407

CERTIFICATE OF DEATH.

101 309 D 93407

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Stockton ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard O Dunn

(a) RESIDENCE NO. 1303 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James G Badman
(Address) 2653 Edmondson Ave

15 Filed ..... 19.. ROBERT G. ... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1924, to Dec 25, 1924, that I last saw him alive on Dec 24, 1924, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

, 19 (Address) 928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12-29-1924

20 UNDERTAKER Arnold Eastman

ADDRESS 766 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93408

100-001

D 93408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 Popleton ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shellman Butts Carter

(a) RESIDENCE NO. 124 Popleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant John Carter
(Address) 124 Popleton St

15 Filed DEC 23 1924, 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1924, to Dec. 27, 1924,

that I last saw alive on Dec. 27, 1924,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Butts M.D., M. D.

, 19 (Address) 111 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12-29-24
20 UNDERTAKER	ADDRESS
Wm D Easton	6 E Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

FEE PAID

Spec.—12-21-21—E.B.R.S.—400 Bks.

D 93409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93409

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 2908 Keyworth ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Goodman

(a) Residence No. 2908 Keyworth ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Isaac Goodman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Aaron Lazarus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Hannah —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Isaac Goodman

(Address) 2908 Keyworth Ave

15-

Filed DEC 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/28/24

17- I HEREBY CERTIFY, That I attended deceased from Several months, 19 to Dec 28 19 24

that I last saw h.e alive on Dec 28 19 24

and that death occurred, on the date stated above, at 1.29 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Several years (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

about 12 to 15 years (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Henry M. Bayley M. D

Dec 29 1924 (Address) 4505 N. Leduck St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, 12/29 1924

20-UNDERTAKER, Jack Louis ADDRESS 1439 E Balt St

In plain terms, so that it may be properly classified. Exact statement of cause of death. Use instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93410 HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D 93410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hosp. St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank Reed Blankenship

(a) Residence No. 2314 E Baltimore St., Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 16 1917

7-AGE. 7 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Boy

(b) General nature of Industry, business, or establishment in which employed (or employer). 200

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Wm Blankenship

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Catherine Lentz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Wm Blankenship

(Address) 2314 E Baltimore

15- Filed DEC 29 1924 ROBERT P. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 28 1924

17- I HEREBY CERTIFY, That I attended deceased from December 5 1924 to Dec 28 1924

that I last saw him alive on Dec 28 1924

and that death occurred, on the date stated above, at 4.00 p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Laryn & Pharyngeal

(Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos 10 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Pos. culture for Dipth

12/29, 1924 (Signed) Myron C. Tuell M. D.

(Address) Sydenham Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL. December 29 1924

20-UNDERTAKER. [illegible] Dyer & Son — ADDRESS 975 Hanover

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93411

CERTIFICATE OF DEATH.

161-001 D 93411

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Bloom ST., 14 WARD)

2-FULL NAME Baby boy Sales

(a) RESIDENCE No. 533 Bloom ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. 10 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Owen Sales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Margaret Sales

(Address) 533 Bloom St.

15 Filed DEC 29 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1924, to Dec. 27, 1924, that I last saw him alive on Dec. 27, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Alexander Mowry, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Given Cemetery	Dec 29, 1924

20 UNDERTAKER Mrs R A Elliott ADDRESS 1725- Westland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.P.R.S.—400 Bks.

D 93412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93412

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1814 N. Chester St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Pepplet

(a) Residence No. 1814 N. Chester St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Pepplet

6-DATE OF BIRTH (month, day and year) June 8 1879

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Alexander Pepplet

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Euphemia Brandstieter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Margaret A. Pepplet
(Address) 1814 N. Chester

15- Filed ..... 192.. ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 27 1924

17- I HEREBY CERTIFY, That I attended deceased from December 21 1924 to December 27 1924 that I last saw him alive on December 27 1924 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Albert Eisenberg M. D.

Dec 28 1924 (Address) 2027 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL, Dec 29 1924

20-UNDERTAKER: John O. Mitchell ADDRESS: 1201 W Fayette

In plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Ikel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93413

CERTIFICATE OF DEATH.

90 D 93413

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Pisiss of Pres. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary - Ann Ikel

(a) Residence No. Preston & Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 1855

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). City

PARENTS.

10-NAME OF FATHER. Geo Ickleman

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Constance

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) Sister Frances

(Address) Preston & Caroline

15- Filed DEC 29 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Record 19.... to 19....., that I last saw her alive on Dec 25, 1924, and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Dec 27, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem

DATE OF BURIAL. Dec 30 1924

20-UNDERTAKER. J. A. Moran

ADDRESS 3000 E. Baltimore

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is Very Important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93414 ✓

CERTIFICATE OF DEATH.

D 93414

113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norval Allen Boothroyd

(a) RESIDENCE No 2223 Callow Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Nov 15/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Claude O. Boothroyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Beacon N. Y.

12 MAIDEN NAME OF MOTHER Hazel M. Emrick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Syracuse N.Y.

14 Informant Claude O. Boothroyd
(Address) 2223 Callow Ave

15 Filed 12 29 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Gastro-Intestinal Indigest (Autopsy at Hopkins-Hyperemia of intestines-cystic thryoid-enlarged mesenreric glands)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Callis, M. D.
(Coroner.)

12/27/24 192 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beacon Dutchess Co. New York	Dec 29 1924
20 UNDERTAKER Virginia Ry Express	ADDRESS
John F. Denby	715 Eutaw St

Spec.—1-12-23—M&T—500 Blks.

D 93415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93415

CERTIFICATE OF DEATH.

X 103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Monroe Mitchell

(a) RESIDENCE NO. 1700 Bolton ST., WARD Relay Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie R. Mitchell

6 DATE OF BIRTH (month, day, and year) Aug 3. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher. 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Relay. Md

PARENTS

10 NAME OF FATHER Perry D. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Mrs. Susie Mitchell (Address) 1700 Bolton St.

15 Filed DEC 29 1924, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23d, 19 24, to Dec 28th, 19 24, that I last saw him alive on Dec 27th, 19 24, and that death occurred, on the date stated above, at 10 35 a. m.

The CAUSE OF DEATH* was as follows:

Unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. 12 hrs ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Frederick U. Reuter, M. D.

Dec 28 1924 (Address) Relay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL Dec 30 1924

20 UNDERTAKER Wm J Pickner & Sons ADDRESS North Ave

CAUSE OF DEATH MUST be plainly written. Avoid use of abbreviations. See instructions on back of certificates.

Spec.–12-23-21–E.B.R.S.–400 Bks.

D 93416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93416

CERTIFICATE OF DEATH.

101-0

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3917 Norfolk Ave St., 15 Ward)

2-FULL NAME Mary Elizabeth Alberger

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3917 Norfolk Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Aug 6, 1866

7-AGE: 58 yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Queenstown Co Md.

PARENTS:

10-NAME OF FATHER: Wm A. Alberger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Sarah E. Diggins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant) Mrs Margaret Hallowell (Address) 3917 Norfolk Ave

15- Filed ... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924 to Dec 27, 1924 that I last saw h[illegible] alive on Dec 27, 1924 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Homer L. Dodd, M. D.

12/28, 1924 (Address) 735 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Sudlersville, Md. — DATE OF BURIAL, Dec. 29, 1924

20-UNDERTAKER: Wm J Tucker Sons — ADDRESS Northern

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93417 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93417

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 104 Cypress St., 25th Ward)

2-FULL NAME Virgie Clark

(a) Residence No. 1603 Pennington Ave. St., Ward 25th.
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married~~ Widowed, ~~or Divorced,~~ (Write the word) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Clark

6-DATE OF BIRTH (month, day and year) Feb. 9, 1871

7-AGE, 53 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, John Kessler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) James L. Clark
(Address) Pennington Ave. & Stanbury Rd.

15- Filed ..... 192.... Registrar.

DEC 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 26-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1924 to Dec. 26, 1924 that I last saw her alive on Dec. 23, 1924 and that death occurred, on the date stated above, at 5 A. m. The CAUSE OF DEATH* was as follows:

Chronic Interstetial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. Urine.

(Signed) Wm. Lee Howard, M. D.

Dec 28, 1924 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Cross R.R. | DATE OF BURIAL, Dec. 30, 1924

20-UNDERTAKER, Margate & Tilghman | ADDRESS 1422 Light St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93418

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2635 Hudson Street St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Poznaniak

(a) Residence No. 2635 Hudson Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 2 1898

7-AGE	If LESS than 1 day,
26 yrs. 10 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Bander in Cigar

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer: Lakewood Ave

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Frank Poznaniak

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Magdalena Lijewski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant): Mr. Frank Poznaniak

(Address): 2635 Hudson Street

15- Filed Dec 29 1924 Robert T. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 27/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1924 to Dec 27, 1924 that I last saw h. Alive on Dec 26, 1924 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Terminal Tuberculosis
Pneumonia

I. B. (Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. 6 mos. ... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Sputum

(Signed) ..., M. D.

, 19 (Address) 1803 Bank St

*State the Disease Causing Death, or in deaths from violent causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem.	Dec. 30 1924

20-UNDERTAKER, John McWeber ADDRESS 1803 Bank St

in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Mary . Krzeszewska

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93419

D 93419

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 Bank ST., 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maryanne Krzeszewska

2035 Bank

(a) RESIDENCE No ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14
Informant Mr Michael Krzeszewski
(Address) 2035 Bank Street

15
Filed DEC 29 1924, 192 Burial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

(Signed) ..... M. D.

(Coroner.)

12/26/24 192 (Address) 1736 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Dec. 29. 1924

20 UNDERTAKER	ADDRESS
John McWeber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93420

CERTIFICATE OF DEATH.

REGISTERED NO. 161-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1618 N Bethel ST., 8 WARD)

(Wiesner)

2-FULL NAME Embryonic

(a) RESIDENCE NO. 1618 N Bethel ST., WARD

(Usual place of abode) Embryonic (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Embryo

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Embryo

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, 1 hr. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Embryonic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Richard Wiesner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Gertrude Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): JOHNS

15 Filed ... 19 ... Registrar

DEC 29 1924

Robert F. Harrison

Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1924, to Dec 29, 1924, that I last saw her alive on Dec 29, 1924, and that death occurred, on the date stated above, at 12 0 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

about 5 months

Pregnancy

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Carman, M. D.

12-27-1924 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Dept. of Health. DEC 29 1924

For Wm. R. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93421

CERTIFICATE OF DEATH.

D 93421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 Church Ave St., Violetteville WARD) Md.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P. Lewis

(a) RESIDENCE NO. 126 Church Ave (Violetteville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9 1923

7 AGE Years 1 Months 8 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lloyd L Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rae Thorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lloyd L Lewis

(Address) 126 Edmondson Ave

15 Filed DEC 29 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 19 24

17

I HEREBY CERTIFY, That I attended deceased from Dec 13, 19 24, to Dec 27, 19 24, that I last saw h alive on Dec 27, 19 24, and that death occurred, on the date stated above, at 3-50 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Labor Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Endocarditis & Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert F Nitsch, M. D.

12/28 19 24 (Address) 2151 Bolton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/30/24
20 UNDERTAKER Joyce A Farley	ADDRESS Fulton Fayette

MATION should be careful, accurate, complete. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93422

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. Bay View Asylum Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kowalski

(a) Residence No. 1001 Kenwood Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., If of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874.

7-AGE 50 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country) Poland

PARENTS.

10-NAME OF FATHER, Wladimir Kowalski

11-BIRTHPLACE OF FATHER (city or town)..... Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Katie Gibas

13-BIRTHPLACE OF MOTHER (city or town)..... Poland (State or Country),

14- (Informant) Hospital Records

(Address) Bay View Hospital

15- Robert P. Harrison,

Filed ..... 192..... Registrar.

C 2 9 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec-24-24.

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1924 to Dec 24 1924

that I last saw h[illegible] alive on Dec 24 1924

and that death occurred, on the date stated above, at 830P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lower portion of esophagus & Cardiac end of stomach Malignant obstruction of lower portion of esophagus (Operation) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock.

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? 1001 Kenwood Ave.

Did an operation precede death? yes Date of Dec 24-24.

Was there an autopsy? No.

What test confirmed diagnosis? Chemical & Lab. Tests

(Signed) Dr. P. Champer M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Rosary Cem	Dec 30, 1924
20-UNDERTAKER.	ADDRESS
Stephen J. Frankowski	1018 Kenwood Ave

In plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93423

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1626 E 29th. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Haske

(a) Residence No. 1626 E 29th St., 9 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 29 1924

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 1/24 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Bernard E Haske

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Catherine A Schaub

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Bernard E. Haske

(Address) 1626 E 29th St

15- Filed DEC 29 1924 Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 29 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 29 1924 to Dec 29 1924, that I last saw h.. alive on Dec 29 1924 and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia

Congenital Malformation

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) B P Henry MD M. D.

12/29, 1924 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec. 29, 1924

20-UNDERTAKER, Wendell Duffield — ADDRESS 37 Dam 4

In plain terms, so that everyone can understand. Please follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Murray 1517 Edmondson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93424

CERTIFICATE OF DEATH.

129 D 93424

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 West Lanvale ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. A. Bryant

(a) RESIDENCE NO. 1534 West Lanvale ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mald 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Bryant

6 DATE OF BIRTH (month, day, and year) June 8- 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Emma A. Bryant 1534 W. Lanvale

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

C 29524 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924, to Dec 27, 1924.

that I last saw h live on Dec 26, 1924

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Oliver Murray, M. D.

, 19 (Address) 1517 Edmondson Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 12/30 1924

20 UNDERTAKER William Cook — ADDRESS 502 E Nath

INFORMATION SHOULD BE GIVEN by person best acquainted with facts. Exact statement of OCCUPATION must be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93425

CERTIFICATE OF DEATH.

100

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lane

(a) RESIDENCE No. 1817 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. Carolina
(State or country)

PARENTS

10 NAME OF FATHER Dale Anderson

11 BIRTHPLACE OF FATHER (city or town) N. C
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) N. C
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ... 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-23, 1924, to 12-27, 1924.

that I last saw her alive on 12-27, 1924

and that death occurred, on the date stated above, at 5-20 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) Claude G. Dean, M. D.

12-27 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel County

DATE OF BURIAL Dec 31 1924

20 UNDERTAKER George J. Rust

ADDRESS 1735 Harford Ave.

29 1924

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93426

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Aisquith ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Kearney

(a) RESIDENCE NO. 1604 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Catherine Kearney

(Address) 1604 Aisquith St

15 Filed 1924 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Dec 26, 1924

that I last saw him alive on Dec 20, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) 1 yrs. 10 mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Anderson, M. D.

, 19 (Address) 1714 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cem. Long Green Md

DATE OF BURIAL: 12/30 1924

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

BEFORE MAKING OUT CERTIFICATE, see that the CAUSE OF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

C2 9 1924

Spec.—1-10-21—M&T—1500 Bks.

D 93427

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Senchekus

(a) RESIDENCE NO. 1837 Clifton Ave ST., ... WARD New York
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15/1884

7 AGE: Years 40 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Candy
(b) General nature of industry, business, or establishment in which employed (or employer): Maker.
(c) Name of employer: Own.

9 BIRTHPLACE (city or town) (State or country): Greece.

PARENTS
10 NAME OF FATHER: Ly Senchekus.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece.
12 MAIDEN NAME OF MOTHER: Mary Gurkis
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece.

14 Informant: S Senchekus
(Address) 1837 Clifton Ave

15 Filed ..... 19 ..... Registrar

C 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-26-24, 19 , to 12-29, 1924.
that I last saw him alive on 12-27, 1924.
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:

Septicaemia (staphylococcus Hemolyticus)
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidore S. Frey, M. D.
Dec. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wood Lawn Cemy. DATE OF BURIAL: Dec 30 1924

20 UNDERTAKER: Geo. F. Rusby ADDRESS 735 Hartford Ave

Information should be correctly supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93428

HEALTH DEPARTMENT—CITY OF BALTIMORE

+ 100-001

D 93428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie M. Toulson

(a) RESIDENCE NO. Rock Hall, Maryland. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Authur Toulson

6 DATE OF BIRTH (month, day, and year) July 7, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent County Maryland

PARENTS

10 NAME OF FATHER James W. Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland I

12 MAIDEN NAME OF MOTHER Sarah Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Annie Toulson
(Address) Rock Hall, Md.

15 Filed 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1924, to Dec. 29, 1924, that I last saw her alive on Dec 29, 1924, and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (5 weeks)
Neuritis in left shoulder (3 mo)
Proctitis (1 week duration)
Chronic Myocarditis (years)
Arteriosclerosis (years)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac failure (1 hr)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Undersumptions M. D.

, 19 (Address) McGaw Mass

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilkerson Grave Yard near McBurneys Queen Anne Co, Md. DATE OF BURIAL Dec. 31 1924

20 UNDERTAKER Wilbur W. Shriver ADDRESS 1018 Edmondson Ave

IMPORTANT: Should be carefully prepared, so that it may be properly classified. Exact statements of occupations and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of occupations and CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93429

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 228 N. Bethel St. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Sheeran

(a) Residence No. 228 N. Bethel St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Sheeran

6-DATE OF BIRTH (month, day and year) Aug. 5th, 1837

7-AGE.	If LESS than 1 day.
87 yrs. 4 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9-BIRTHPLACE (city or town)

(State or Country). New York

PARENTS

10-NAME OF FATHER. Andrew Murtaugh

11-BIRTHPLACE OF FATHER (city or town)

(State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ann Sullholland

13-BIRTHPLACE OF MOTHER (city or town)

(State or Country). Ireland

14-

(Informant) Mrs. McKinley

(Address) 228 N. Bethel st.

15-

Filed 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 27th, 1924

17- I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1922 to Dec. 27, 1924

that I last saw h.. alive on Dec. 27, 1924

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green M. D.

12-29, 1924 (Address) 170 Cinquin St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cemetery	12/30/ 19 24
20-UNDERTAKER.	ADDRESS
E. I. Fanning & Son	1938 E. Lafayette Ave

In plain terms, so that it may be properly classified. Exact statement of cause of death. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93430 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93430

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T.O'Leary.

(a) RESIDENCE NO. 1306 N.Chester St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Mary O'Leary.

6 DATE OF BIRTH (month, day, and year) Vebruary 15.1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer: Wm.E.Woodall Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John T.O'Leary.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Margaret McSweeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: John T.O'Leary.(son)

(Address): 1306 N.Chester St.

15 Filed ....., 192.... [illegible] Registrar

C 2 9 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 26, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

Fracture of the 3rd Cervical Vertebra.

Accidental fall from a scaffold.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Oedema.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Leinhardt, M. D. (Coroner.)

Dec. 29th. 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Wm. E. Woodall ship yard. Dec. 9th. 1924.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New. Cathedral — DATE OF BURIAL: Dec 30 1924

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Balto St.

mation should be carefully supplied. Ac-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Oc-
TION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93431 463

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 7 + 24

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith May Jordan

(a) RESIDENCE No. 122 H St Sparrows Point Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): July ? 1924

7 AGE: Years ? | Months 5 | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Edward Jordan
11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa
12 MAIDEN NAME OF MOTHER: Jennie Davis
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed 2 9 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1924, to Dec 28, 1924, that I last saw her alive on Dec 28, 1924, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Meningococcus meningitis

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12/27/24

Was there an autopsy? Yes

What test confirmed diagnosis? Culture of organism

(Signed) Edmund H Kelper, M. D.

12/29, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec. 30, 1924

20 UNDERTAKER: John A. Moran 6100 — ADDRESS: E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93432

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 514 Oxford St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella P. Chesley

(a) Residence No. 514 Oxford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Chesley

6-DATE OF BIRTH (month, day and year): Oct-10-1870

7-AGE: 54 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Richmond Virginia

PARENTS:

10-NAME OF FATHER: Joseph Gilpin

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Richmond Virginia

12-MAIDEN NAME OF MOTHER: Catherine Bird

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Petersburg Virginia

14-

(Informant): Cora Stanmire

(Address): 514 Oxford St

15-

Filed, 192 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from Oct-15 19.24 to Dec. 27 19.24

that I last saw h[illegible] alive on Dec. 27, 19.24

and that death occurred, on the date stated above, at 1.05 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia - Chronic Myocarditis

Emphysema 1 yrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chr Diffuse Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine +++

(Signed) Dr J Rumschlum M. D.

12/29 1924 (Address) 1211 Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem.	Dec 30 1924
20-UNDERTAKER.	ADDRESS
Samuel T Wesley	1118 Eden St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is required. Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93433

D 93433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 937 W. Saratoga ST., 18 WARD)

2-FULL NAME Edw Scott

(a) RESIDENCE No 937 W. Saratoga St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Marr'd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Miller (daughter) (Address) 212 Lynn Real Ave

15 Filed DEC 30 1924, 192 Robert F. Harrison, Registrar

Burial Permit Mark

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 25- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said ..... find that said deceased came to ~~Inquest, autopsy or inquiry.~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ..... yrs. Don't Know mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) M K Gensch, M. D. (Coroner.)

12-29, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 30 1924
20 UNDERTAKER Samuel J Hensley	ADDRESS 748 W Baltimore

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 93434

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 St. Sambard ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rice Ackermann

(a) RESIDENCE. NO. 1700 St. Sambard ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND OF~~ WIFE of Edward Ackermann

6 DATE OF BIRTH (month, day, and year) Apl. 12-1844

7 AGE — Years: 80 — Months: 8 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Margaret Ackermann, 1700 St. Sambard St.

15 Filed ..... Robert F. Harrison, Registrar

C 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1924, to Dec 27, 1924, that I last saw her alive on Dec 27, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cop, M. D.

12/29 1924 (Address) 54 S Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec. 30/1924

20 UNDERTAKER: Elmer V. Conklin — ADDRESS: 924 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93435

CERTIFICATE OF DEATH.

38

D 93435

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Pryor

(a) RESIDENCE NO. 732 Dover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nippie Pryor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) White Hall S. C (State or country)

PARENTS

10 NAME OF FATHER Silius Pryor

11 BIRTHPLACE OF FATHER (city or town) S. C (State or country)

12 MAIDEN NAME OF MOTHER un. known

13 BIRTHPLACE OF MOTHER (city or town) S. C (State or country)

14 Informant Henry J. Chisolm

(Address) 732 Dover St.

15 Filed DEC 30 1924 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1924, to Dec 27 1924, that I last saw him alive on Dec 27 1924, and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteria Sclerosis

Probably Syphilitic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Oedema of lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) M. Alexander Avery, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bay View cemetery — DATE OF BURIAL: Dec 31 1924

20 UNDERTAKER: Edward Bryan — ADDRESS: 631 Carlton St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93436 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 93436

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

Registered No.....

City of BALTIMORE: (No.....St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Wilson

(a) Residence No. 622 N. Bond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Blk.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~(Husband of)~~ WIFE of Wm. J. Wilson

6-DATE OF BIRTH (month, day and year) 1877.

7-AGE. 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Stanley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Charity Clark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-

(Informant) Bay View Hospital

(Address) Balto., Md.

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

DEC 30 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/26/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924 to Dec 25, 1924

that I last saw h.er alive on Dec. 25, 1924

and that death occurred, on the date stated above, at 1.05 A.m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

+ ~~General Paralysis of the Insane~~

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis of the Insane

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + autopsy

(Signed) H. J. Equitz M.D.

, 19 (Address) Bay View Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Bury cemetery	Dec 30, 1924
20-UNDERTAKER, Edward Bryan	ADDRESS 1631 Orleans St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93437

CERTIFICATE OF DEATH.

100 D 93437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

2-FULL NAME George Stevens

(a) RESIDENCE NO. Bay View Asylum (404 N Eden St) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-26, 1924, to 12-26, 1924 that I last saw him alive on 12-26, 1924 and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lgt.

(Signed) Claude T. Evans M. D.

12-27 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bury Cemetery	Dec 30 1924
20 UNDERTAKER	ADDRESS 1631
Edward Bryan	Arlington St

mation should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1719 D 93438

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 93438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Abraham Albert

(a) RESIDENCE NO. 213 N Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER Ida Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 21 - 1924 to Dec 25 1924, that I last saw h alive on Dec 25 1924, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Primary)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Syphilis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

op Bury cemetery — dec 31 1924

20 UNDERTAKER — ADDRESS

Edward Bryan — 1631 Orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93439

CERTIFICATE OF DEATH.

90 D 93439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2421 Eldering ST. 13 WARD)

2-FULL NAME Frances Edwards

(a) RESIDENCE No. 2421 Elbing ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
75.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) Ad
(c) Name of employer

9 BIRTHPLACE (city or town) Ind
(State or country)

PARENTS

10 NAME OF FATHER George Vandeler

11 BIRTHPLACE OF FATHER (city or town) Ind
(State or country)

12 MAIDEN NAME OF MOTHER Frances Stewart

13 BIRTHPLACE OF MOTHER (city or town) Ind
(State or country)

14 Informant Hattie Cornish
(Address) 2319 Druid Park

15 Filed DEC 30 1924, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Thrombosis
Heart
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 27, 1924 (Address) 1632 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 30 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mc Kinnon

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93440

D 7618 93440

CERTIFICATE OF DEATH.

45X

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Ike Kinnon

(a) RESIDENCE NO. 7 N Castle St ST., WARD South Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M. Kinnon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Sam Kinnon

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Emy Prince

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Rumola

(Address)

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 - , 1924, to Dec 23 , 1924, that I last saw h- alive on Dec 23 - , 1924, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Colloid carcinoma - primary in transverse colon

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Clio S.C.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) M. S. Guttmacher, M. D.

, 19 (Address) Johns Hopkins H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Dec 30 1924

20 UNDERTAKER Chas. H. Johnson — ADDRESS 416 N. Carlin

INFORMATION should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Avoid use of abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Morison

D 93441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 93441

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 827 Saint Paul ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hawkins Morison

(a) RESIDENCE NO. 827 Saint Paul ST., WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dr. John T. Brown Morison

6 DATE OF BIRTH (month, day, and year) Dec 1, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	71	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Washington Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Eleanor A. Jettings

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Fanny B. Morison

(Address) 827 St Paul St Balto

15 Filed DEC 30 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1924, to Dec 28, 1924,

that I last saw h... alive on Dec 27, 1924,

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus (Secondary)

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 1924

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Carl O'Donovan, M. D.

..., 19... (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12-30 1924
20 UNDERTAKER	**ADDRESS**
Henry W. Justis Sons Co	Richard & McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D 93442
Registered No.

1-PLACE OF DEATH
City of BALTIMORE: (No. 910 N. Dallas St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret K. Brader

(a) Residence No. 910 N. Dallas St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: the late John H. Brader

6-DATE OF BIRTH (month, day and year): August 9 1849

7-AGE: 75 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:
10-NAME OF FATHER: Wm. Merkel
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Not Known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-Informant: Mrs. Margaret Brader
(Address): 910 N. Dallas St

15-Filed DEC 30 1924 by ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 29 1924

I HEREBY CERTIFY, That I attended deceased from Dec 14 1924 to Dec 29 1924
that I last saw her alive on Dec 14 1924
and that death occurred, on the date stated above, at 3:45 P. m.
The CAUSE OF DEATH was as follows:

Grippe

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Schmidt M.D. (Address) 1201 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — DATE OF BURIAL: Jan. 2 1925

20-UNDERTAKER: Henry Hosch Son — ADDRESS: 1301 E Eager

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93443

CERTIFICATE OF DEATH.

10 1 D 93443

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 Ramsay ST., 19 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Meeks

(a) RESIDENCE NO. 1337 Ramsay (Usual place of abode) ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Meeks

6 DATE OF BIRTH (month, day, and year) Dec 29 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rod Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Carrige Shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Howard Meeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margett Lands

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary E. Meeks

(Address) 1337 Ramsay St

15 DEC 30 1924 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Dec 27, 1924, that I last saw h alive on Dec 27, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Chas A Carter M. D.

12/29 1924 (Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine	Dec 31 1924
20 UNDERTAKER	ADDRESS
John Fields	1200 W Lombard

MATION should be entered IN ENGLISH WORDS. Abbreviations should not be used except when necessary, and then only such as are well understood. Ages, dates of birth, and dates of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93444

CERTIFICATE OF DEATH.

155 D 93444

1-PLACE OF DEATH Bay View Hospital — Registered No.

City of BALTIMORE: (No. ... St., 15 ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Mitchell

(a) Residence No. 1811 N. Mount St., ... Ward ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Blk

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~(or)~~ WIFE of Blasing Mitchell

6-DATE OF BIRTH (month, day and year) 1893

7-AGE. 31 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stevedore
(b) General nature of Industry, business, or establishment in which employed (or employer) 074
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do.

14- (Informant) Bay View Hospital (Address) Balto., Md.

15- Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/28/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Dec 29, 1924, that I last saw ~~him~~ alive on Dec 27, 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Streptococcic)

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Osteomyelitis

Tbc Psychosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Autopsy findings

(Signed) J. J. McDaniel M.D.

12/29, 1924 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Quantico Station Va. DATE OF BURIAL. Dec 30, 1924

20-UNDERTAKER. Virginia A. Brooks ADDRESS 1463 N. Carey St.

Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Entire instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

D 93445

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 Maryland Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edwin Etchberger

(a) RESIDENCE No. 2501 Maryland Ave ST., 12 WARD Resident.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? 80 yrs. 5 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Etchberger

6 DATE OF BIRTH (month, day, and year): July 24 1844

7 AGE — Years: 80 — Months: 5 — Days: 5 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): " " "

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jas. Etchberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Frances Despeaux

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Miss Kate C. Etchberger Sister

(Address) 2501 Maryland Ave

DEC 30 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1924, to Dec 29 1924, that I last saw him alive on Dec 29 1924, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of larynx

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Hratson, M. D.

Dec 30, 1924 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Dec 31, 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

REASON should be clearly supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. ... statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93446

CERTIFICATE OF DEATH.

D 93446

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital ST., 18 WARD)

2-FULL NAME Edwin Hood Davis

(a) RESIDENCE NO 29 So. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs James Ralston
(Address) 29 So. Carey St

15 Filed ... 192 ROGER K. KRAUTER, Burial Permit Clerk.

DEC 30 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry), thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Geo. B. Horton, M. D.
(Coroner.)

Dec 29, 192 4 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 30th 1924

20 UNDERTAKER A. Jones — ADDRESS 1118 S. Gilmor St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93447

101-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Carter

(a) RESIDENCE NO. Friendly Inn 425 E. 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Carter

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed DEC 30 1924 Registrar ROSELLA A. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/27/1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 1924 to Dec 27 1924.

that I last saw him alive on Dec 27 1924.

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) D C Ceckton M.D.

12/28 1924 (Address) Municipal Hospital-Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Dec 31 1924

20 UNDERTAKER Samuel T. Hinsley ADDRESS 1128 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93448

CERTIFICATE OF DEATH.

124 D 93448

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 16 WARD)

2-FULL NAME Mamie Duncan

(a) RESIDENCE NO. 1021 Rice St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. Duncan

6 DATE OF BIRTH (month, day, and year) Sept 17, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Allendale (State or country) S.C.

PARENTS

10 NAME OF FATHER Enix Duncan

11 BIRTHPLACE OF FATHER (city or town) Allendale (State or country) S.C.

12 MAIDEN NAME OF MOTHER Mamie Williams

13 BIRTHPLACE OF MOTHER (city or town) Allendale (State or country) S.C.

14 Informant Husband Benj Duncan (Address) 1021 Rice

15 Filed ....., 19.... Registrar

ROBERT B. KRAUTER

DEC 30 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1924, to Dec 28, 1924, that I last saw h.. alive on Dec 28, 1924, and that death occurred, on the date stated above, at 12.00 noon.

The CAUSE OF DEATH* was as follows:

Peritonitis due to
Rupture Gall bladder

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Myron G. Tull, M. D.

12/29 19 24 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Estill S.C. DATE OF BURIAL Dec 30 1924

20 UNDERTAKER Samuel F Housley ADDRESS W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93449

CERTIFICATE OF DEATH.

4 X 179 D 93449

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth M. Cornelius.

(a) RESIDENCE NO. Piney Neck. Kent Co. Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Non resident. yrs. mos. ds. 23 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, ~~XXXXXXXXXXXX~~ ~~XXXXXXXX~~ (or) WIFE of James A. Cornelius.

6 DATE OF BIRTH (month, day, and year) April 2, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Piney Neck, Kent Co. Md.

PARENTS

10 NAME OF FATHER Philip R. Apsley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Piney Neck, Kent Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Wollehan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Piney Neck, Kent Co. Md.

14 Informant James A. Cornelius. (husband)
(Address) Piney Neck, Kent Co. Md.

15 Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 30, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxaemia due to extensive burns about back, abdomen and legs. Explosion of oil can while pouring oil on a stove. Accidental death. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt (Coroner.) M. D.

Dec. 30. , 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
In the Mercy Hospital since Dec. 6/24
Where was disease contracted, if not at place of death?
Accident at Piney Neck, Kent Co. Md.
~~Former or usual residence~~ November 22, 1924

19 PLACE OF BURIAL, REMOVAL OR CREMATION Cockeysville Md. DATE OF BURIAL
Wesley Chapel Cemetery Jan 2nd 1924

20 UNDERTAKER Lilly + Zeiler ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93450

CERTIFICATE OF DEATH.

46 D 93450

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2401 E. Jefferson ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Fortmiller

(a) RESIDENCE NO. 2401 E. Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. / mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, ~~or Divorced, (write the word)~~
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Late John S. Fortmiller

6 DATE OF BIRTH (month, day, and year) July 27-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76.	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Dippelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Worch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Evening

(Address) 2401 E. Jefferson St

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1924, to Dec. 28, 1924, that I last saw her alive on Dec 27, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

Vaginal Abscess.

(duration) 28 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) R. Dreyer, M. D.

, 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 30, 24
20 UNDERTAKER	ADDRESS
Wm E. Miller & Son	2334 E. Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93451 — 187-007 — D 93451

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3511 Dillon St. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert H. Hensler .....

(a) Residence No..... Essex, Balto. Co. ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K. Hensler

6-DATE OF BIRTH (month, day and year) Dec. 30-1887

7-AGE	If LESS than 1 day.
36 yrs. 11 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Pipe Fitter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer.... Standard Oil Co.

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.
10-NAME OF FATHER, Robert Hensler
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore, Md.
12-MAIDEN NAME OF MOTHER, Annie Jubb
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore, Md.

14- (Informant) Mary K. Hensler
(Address) Essex, Balto. Co. Md.

15-
Filed DEC 30 1924 19.. Robert R. Kahl Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 28-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5 19 24 to December 26 19 24
that I last saw h.. alive on December 26 19 24
and that death occurred, on the date stated above, at 12.55 A m.
The CAUSE OF DEATH* was as follows:

Basilar meningitis (Coma)

(Duration) ..... yrs. ..... mos. few ds.

CONTRIBUTORY (Secondary) Fractured base of skull

(Duration) ..... yrs. ..... mos. 53 ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis?.....

(Signed) A. W. Kocher M. D
19 (Address) 31 E. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parklawn	Dec. 31 19 24
20-UNDERTAKER,	ADDRESS
Junkler & Junkler	1734 Eager

Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Baltimore, Md., Dec. 29th, 1924.

Case of Robert H. Hensler

red November 6th, 1924 - When he was engaged in making a
brass coil with one of our pipe machines. The method used
this work was to fasten one end of the 3/4" pipe to a 6"
by means of a "U" bolt. In order to make the 3/4" pipe
tightly around the 6" pipe, the 3/4" pipe was run through
piece of 2" pipe which acted as a handle for this purpose.
n the coil was wound within 2' of the end, he stopped the
chine and removed the 2" pipe. He had machine started again
d attempted to hold the end of the 3/4" pipe with his hands
h the idea of making another turn on the coil. He held the
of the pipe long enough to take up the spring in the coil
when it reached the bending point, Hensler was forced to
ease his hold on the 3/4" pipe causing the 2' end to re-
and strike him on the head.

D. J. Jones M. D.
Standard Oil Co. (N.J.)
Refinery
Baltimore, Md.

Spec.—1-10-21—M&T—1500 Blks.

D 93452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 93452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 540 Mc Mechen ST., 14 WARD)

REGISTERED No. D 93452

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos Ross.

(a) RESIDENCE NO. 540 Mc Mechen ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Ross

6 DATE OF BIRTH (month, day, and year): Unknown, 1873

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

023

PARENTS

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mamie Ross 540 Mc Mechen

15 Filed ... 19 ... DEC 30 1924 ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1924, to Dec 17, 1924

that I last saw h— alive on Dec 12, 1924

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos 16 da.

CONTRIBUTORY (Secondary): Carbohemia

(duration) yrs. mos. 16 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) C. W. Hosea M. D.

(Address) 712 S Broad St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Dec 30 1924

20 UNDERTAKER: Edward T. Hawley

ADDRESS: 518 N Eddie

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93453

90 c

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 N Franklin St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Thompson

(a) Residence No. 806 N. Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fmal

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1897

7-AGE: 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balt Md

PARENTS:

10-NAME OF FATHER: Wm Thompson

11-BIRTHPLACE OF FATHER (City or town) (State or Country): Balt Md

12-MAIDEN NAME OF MOTHER: Dora Jones

13-BIRTHPLACE OF MOTHER (City or town) (State or Country): Balt Md

14- (Informant): Esther Thompson

(Address) 806 W. Franklin St

15- Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924 to Dec 29, 1924

that I last saw her alive on Dec 28, 1924

and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M Carey, M. D.

, 19 (Address) 763 George

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

DATE OF BURIAL: 12-31-24

20-UNDERTAKER: Dan'l Carey

ADDRESS 916 Eutaw

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93454

CERTIFICATE OF DEATH.

4 129 D 93454

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 403 Tyson St ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Lee

(a) RESIDENCE NO 403 Tyson St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Dont Know yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Dont Know

14 Informant Robt Easton
(Address) 916 E Oa

15 Filed DEC 30 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (her) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W H Fowble, M. D. (Coroner.)

12-30 1924 (Address) 1137 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 12-30 1924

20 UNDERTAKER Robt Easton — ADDRESS 916 E Oa St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

93455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 93455

1-PLACE OF DEATH U.S. Marine Hospital No. 1

CITY OF BALTIMORE: (No. Baltimore, Md ST., 14 WARD)

REGISTERED NO. D 93455

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Fuehrer

(a) RESIDENCE NO. 337 Preraman St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mks ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Edward Fuehrer

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) waiter

(c) Name of employer S/S Ester Weems

9 BIRTHPLACE (city or town) Georgia.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Self.
(Address)

15 Filed DEC 30 1924 ROSLER R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1924, to Dec 30, 1924, that I last saw him alive on Dec 30, 1924, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia,

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Gangrenous Appendicitis

(duration) yrs. mos. 2 4 ds.

18 Where was disease contracted if not at place of death? On board ship

Did an operation precede death? yes Date of Dec 14/24

Was there an autopsy? no

What test confirmed diagnosis? Physical test and Laboratory findings

(Signed) J. J. Fuehrer M. D.

19 (Address) U.S. Marine Hospital No. 1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-31-24

20 UNDERTAKER Dent Earley

ADDRESS 96 Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93456

CERTIFICATE OF DEATH.

101-001 D 93456

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2018 Redgrove Ave ST., 15 WARD)

2-FULL NAME Franz Jacob Hipp

(a) RESIDENCE NO. 2018 Redgrove Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of [redacted] of Eva Hipp

6 DATE OF BIRTH (month, day, and year) May 25 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Shapiro & Co Meat packers

(c) Name of employer Shapiro & Co

9 BIRTHPLACE (city or town) (State or country) Hessen Germany

PARENTS

10 NAME OF FATHER Peter Hipp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown & family

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wife (Eva Hipp)

(Address) 2018 Redgrove Ave

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Mar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1924, to Dec 24, 1924, that I last saw him alive on Dec 24th, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Left Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Samuel H Culver M. D.

, 19 (Address) 4710 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 31 19 24
20 UNDERTAKER Wm Cook	ADDRESS 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93457

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 93457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 St Paul ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Prudence G. Rippard

(a) RESIDENCE NO. 1828 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Rippard

6 DATE OF BIRTH (month, day, and year): 7-26-1849

7 AGE: Years 75 Months 7 Days 4 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10 NAME OF FATHER: George Rippard

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Susanna Jo. Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Anna M. Rippard

(Address): 1828 St Paul Street

15 Filed DEC 30 1924, 19.... ADOLPH R. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1922 to Dec 29 1924

that I last saw her alive on Dec 28 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) L. Bourne Lowe, M. D.

12/30/24 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 1-2-1925

20 UNDERTAKER: William Cook — ADDRESS: 592 E North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

James Stiles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93458

100-001

B 93458

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 414 Wayne st ST., 22 WARD)

2-FULL NAME Mrs James Stiles

(a) RESIDENCE NO. 414 Wayne st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66 Yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14
Informant Rose Stiles
(Address) 414 Wayne St

15
Filed DEC 30 1924 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or inquiry.~~
thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Cold

(duration) ..... yrs. ..... mos ..... ds.

(Signed) W K Grouch, M. D.
(Coroner.)

12-29, 1924 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 31 1924
20 UNDERTAKER	ADDRESS
J. L. & Bro's Son	1810 Mon'g

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93459

CERTIFICATE OF DEATH.

24001

D 93459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3042 St. Paul ST., 17 WARD)

2-FULL NAME Hannah E. Kriel

(a) RESIDENCE NO. 3042 St. Paul ST., WARD

(Usual place of abode)

Length of residence in city or towo where death occurred 87 yrs. 5 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles G. Kriel

6 DATE OF BIRTH (month, day, and year) July 23 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Walter M. Kriel

(Address) 3042 St. Paul St.

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1924, to Dec 29, 1924

that I last saw h.. alive on Dec 28, 1924

and that death occurred, on the date stated above, at 5.50 A. m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) one yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Julius Friedenwald M. D.

Dec 30, 1924 (Address) 10 13 St Charles Le

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Dec 31 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93460

CERTIFICATE OF DEATH.

89 D 93460

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 East Biddle St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME N. Winslow Williams.

(a) RESIDENCE NO. 2 East Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widow or widower of~~ HUSBAND of ~~(or wife of)~~ Ann Williams.

6 DATE OF BIRTH (month, day, and year) August 26, 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Lawyer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cleveland Ohio.

PARENTS

10 NAME OF FATHER John Butler Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston S.C.

12 MAIDEN NAME OF MOTHER Kate Winslow.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cleveland Ohio.

14 Informant John Winslow Williams.(son).
(Address) 2 East Biddle Street.

15 Filed DEC 30 1924, 192 ROBERT R. KRAUTER, Registrar
~~Burial Permit Clerk~~

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.
Obstruction of the Coronary Arteries.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Dec. 29th, 1924. (Address) 1014 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Dec 31st 1924

20 UNDERTAKER Henry W. Jenkins Sons ADDRESS Mt. Carlton & Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 319 Gwynn Ave St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Eliza L. Montray

(a) Residence No. 319 Gwynn Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 5, 1838

7-AGE, 86 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Unknown

14- (Informant) Mrs. Louis Grollock

(Address) 14 W. Woodlawn Ave

15- Filed DEC 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 30. 24

17- I HEREBY CERTIFY, That I attended deceased from Oct 4, 1924, to Dec 30, 1924, that I last saw h[illegible] alive on Dec 29, 1924, and that death occurred, on the date stated above, at 2[illegible] a.m. The CAUSE OF DEATH* was as follows:

Carcinoma - Liver

(Duration) few yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) M. Brennan Hurd, M. D.

Dec 30. 1924 (Address) 626 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, Jan. 1, 1925

20-UNDERTAKER, George J. Smith — ADDRESS 1532 Hollins St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 619 N. Fulton Ave ST. 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie M. Merryman

(a) RESIDENCE No. (Usual place of abode) 619 N. Fulton ave ST., WARD

Length of residence in city or town where death occurred 67 yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Edward A. Merryman

6 DATE OF BIRTH (month, day, and year) Mch 29 1857

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	67	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph W Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bay

12 MAIDEN NAME OF MOTHER Elizabeth M Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Edward A Merryman
(Address) 619 N. Fulton ave

15 Filed DEC 30 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Dec. 30, 1924 (Address) 2802 Eastern ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Dec 31 1924
20 UNDERTAKER	ADDRESS
John O Mitchell	320 W Fayette

TION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1771 D 93463

100001 D 93463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7 WARD)

2-FULL NAME Elaine Tischa

(a) RESIDENCE NO. 1001 N. Dallas ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
—	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Frank Tischa

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Violet Hauck

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1924. to Dec 27, 1924.

that I last saw her alive on Dec 27, 1924.

and that death occurred, on the date stated above, at 5 00 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edmund H. Kemper, M. D.

12/29 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 30 1924
20 UNDERTAKER Frank Crockett	ADDRESS 1906 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93464

100-001

CERTIFICATE OF DEATH.

D 93464

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Union Memorial Hosp. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles W. Zile

(a) Residence No. 2823 Riggs Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Cora E Zile

6-DATE OF BIRTH (month, day and year) Aug 10, 1866

7-AGE: 58 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer): 066

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS

10-NAME OF FATHER, Leonard Zile

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Stevenson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Cora E Zile

(Address) 2823 Riggs Ave

15-DEC 30 1924 Filed ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 28, 1924

17-I HEREBY CERTIFY, That I attended deceased from Dec 26, 19 24 to Dec 28, 19 24

that I last saw h.. alive on Dec 28, 19 24

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. Austin Pearre, M. D.

, 19 (Address) Union Memorial Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Orford Pa	Dec 31, 1924
20-UNDERTAKER	ADDRESS
W M Routson	2238 N Monroe

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93465 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93465

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Homer

(a) Residence No. 1728 Maryland St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1887

7-AGE.	If LESS than 1 day.
37 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 620

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Alabama

PARENTS.

10-NAME OF FATHER, George Homer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Alabama

12-MAIDEN NAME OF MOTHER, Ella King

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Alabama

14- (Informant) Municipal Hospital Records

(Address) .....

15- Robert F. Harrison, JOHNS

....., 192.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-26-24

17- I HEREBY CERTIFY, That I attended deceased from 12-2 1924 to 12-26, 1924, that I last saw him alive on 12-24, 1924, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis (?)
Aortic Insufficiency
Myocardial Insufficiency

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) Claude G. Homer, M. D.

12-26, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
HOPKINS HOSPITAL	....., 19....

20-UNDERTAKER Director of Health, ADDRESS DEC 30 1924

Per Wm. H. Ritchie

DEC 30 1924

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93466

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. ..... St., 17 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Calamaro

(a) Residence No. 511 W. Hoffman St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) 1851

7-AGE. 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Hod-carrier

(b) General nature of industry, business, or establishment in which employed (or employer): 135

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do.

14- (Informant) Bay View Hospital

(Address) Balto., Md.

15- Filed ..... 192. ..... Registrar.

~~Clerk~~ ~~Permit Clerk.~~

2059

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/27/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924 to Dec 27, 1924 that I last saw him alive on Dec 27, 1924 and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. E. Goldsmith, M. D.

12/29/, 1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: DEC 30 1924

20-UNDERTAKER: ..... 192. ..... for Health,

DEC 30 1924

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93467

CERTIFICATE OF DEATH.

101 ✓

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST., 76 WARD)

2-FULL NAME John Ripley

(a) RESIDENCE NO. ? ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) U.S.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) .....

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) .....

14 Informant Municipal Hospital Records JOHNS (Address) .....

15 DEC 30 1924 Robert F. Harrison, Registrar
..... 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-24 1924 to 12-27 1924 that I last saw him alive on 12-27 1924 and that death occurred, on the date stated above, at 2m P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude E. Dunn M. D.

12-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 19..

ADDRESS DEC. 30 1924

20 UNDERTAKER [illegible] Bureau of Health,

[illegible] Wm. E. WOODALL

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should write mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93468

CERTIFICATE OF DEATH.

D 93468

1-PLACE OF DEATH — Registered No. 161-09

City of BALTIMORE: (No. 1131 N Fremont St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby White

(a) Residence No. 1131 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	C	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 28-24

7-AGE. yrs. mos. ds. If LESS than 1 day, 18 hrs. or min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Premature Birth

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER, James Stanley

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Pauline White

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

11- (Informant) Pauline White

(Address) 1131 N. Fremont

13- Filed 19 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h... alive on Dec 29 19 24

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. McLane M. D.

, 19 (Address) 1126 Druid Hill

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ... 19...

20-UNDERTAKER, [illegible] Health,

ADDRESS

DEC 30 1924

Per. Wm. E. WOODALL

DEC 30 1924

Deputy Local Clerk.

2102

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93469

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93469

CERTIFICATE OF DEATH.

16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Langrall

(a) RESIDENCE NO. 714 Edgewood ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 min da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/28/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Herbert Lee Langrall

11 BIRTHPLACE OF FATHER (city or town) Somerset Co. (State or country) Somerset Co. Md

12 MAIDEN NAME OF MOTHER Estell Victoria Muir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co. Md

14 Informant Herbert Lee Langrall

(Address) 714 Edgewood Ave

15 Filed DEC 30 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Dec 28, 1924.

that I last saw h[illegible] alive on Dec 28, 1924.

and that death occurred, on the date stated above, at 3 45 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

30 min.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. 30 min mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 12/28/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Robert Smith M. D.

(Address) 2 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Dec 30 1924
20 UNDERTAKER	ADDRESS
Lilly & Zile	403 S. Wolfe St

A B—WRITE PLAINLY, with indelible pencil. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93470

CERTIFICATE OF DEATH.

D 93470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Graff.

(a) RESIDENCE. NO. 1110 South Lakewood Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. 3. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jacob Graff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Willie H. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mother

(Address) .....

15 Filed . 19 Robert F. Harrison Registrar

C 30 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1924, to Dec 30th, 1924, that I last saw her alive on Dec 30th, 1924, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Dyptheria

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1110 S. Lakewood Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Bacteriological

(Signed) Myron G Tull, M. D.

12/30/1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Dec. 31 1924

20 UNDERTAKER Lilly & Zitler ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93471

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1231 S. Carey St., 16 Ward) Registered No. 74

2-FULL NAME Eliza Schrader

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1231 S. Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. C mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pate Henry Schrader

6-DATE OF BIRTH (month, day and year) Jan 9, 1855

7-AGE. 69 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER, Leop

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Daisy Griffith

(Address) 1324 Washington Blvd

15- Filed ..... 19?

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

DEC 30 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 29. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924 to Dec 29, 1924

that I last saw her alive on Dec 29 1924

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Fellinger M. D.

12/30/24 (Address) 682 W Lanvale St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Jan 1, 1925

20-UNDERTAKER, Jos Joerdens Son ADDRESS 2178 Pac

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93472 D 93472

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST., 15 WARD)

2-FULL NAME Mrs Laura Cauliflower

(a) RESIDENCE NO. 3122 Presbury St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Flower

6 DATE OF BIRTH (month, day, and year) Nov-10-1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
36	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.,
(State or country)

PARENTS

10 NAME OF FATHER John Colley

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER ? Garey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md
(State or country)

14 Informant Mrs Laura Cauliflower
(Address) 3122 Presbury St

15 Filed DEC 30 1924, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec-28- , 19 24 , to Dec- 28 , 19 24 , that I last saw her alive on Dec 28 , 19 24 , and that death occurred, on the date stated above, at 1:10 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - (acute dilatation)

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pregnancy (duration) yrs. 7 mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? None -

What test confirmed diagnosis? Clinical

(Signed) Jno Alone Willis, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec 31 1924

20 UNDERTAKER Jos Joerdens Son

ADDRESS 217 S. Bway

D.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93473

CERTIFICATE OF DEATH.

D 93473

1-PLACE OF DEATH Tessier

CITY OF BALTIMORE: (No. 808 Fisher St. ST.; 17 WARD)

REGISTERED No. C 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winslow Oliver

(Residence in Baltimore: No. 808 Fisher St (Tessier sn) St.; 40 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, Married or DIVORCED. (Write the word.)

6-DATE OF BIRTH, ..., 1864
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. O. Thompson

(Address) 808 Fisher St

15- Robert P. Harrison,
Filed ....., 191.....
Registrar.
Burial Permit Clerk.

DEC 30 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7 1923, to Dec 27 1924, that I saw h— alive on Dec 27 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) Joseph J Harrison M. D.

12/29, 1924 (Address) 3210 Pennsylv

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, 12-31-1924

20-UNDERTAKER Dan'l Carter

ADDRESS 916 Pa ave

N.B.—Every item of information should be carefully supplied. AGE should be filled EXACTLY. Illegible or illegal CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93474 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93474

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 E Pratt St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ida Caplan

(a) Residence No. 1111 E Pratt St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Israel

6-DATE OF BIRTH (month, day and year) Mch- 1859

7-AGE. 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 37

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Jack Abramson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Israel Caplan

(Address) 1111 E. pratt st

15- Filed ..... 192... Robert P. Harrison, Registrar.

DEC 30 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 30/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924, to Dec 27, 1924

that I last saw h.. alive on Dec 27, 1924,

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis 1

valvular disease

Antedating a long time

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Edema of lungs, dextrocardia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No Symptoms

What test confirmed diagnosis? Physical signs

(Signed) Frank R. Smith, M. D.

Dec 30, 1924 (Address) 927 N. Calvert St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Henry Fun — DATE OF BURIAL. Dec 31 19 24

20-UNDERTAKER. Jos Levinson & Bro — ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 93475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93475

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Barranjer

(a) RESIDENCE No. 2636 Pennsylvania Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary [illegible] Barranjer

6 DATE OF BIRTH (month, day, and year) Sept 16, 1844

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
80	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Butcher

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Barranjer

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Bruns

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Mrs. Wm. Smith.
(Address) 2636 Pennsylvania Ave.

15 Filed DEC 30 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-22-24, 19..., to 12-30-, 1924,

that I last saw h[illegible] alive on 12-30-, 1924,

and that death occurred, on the date stated above, at 12 40 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Infected left foot.

(duration) yrs. mos. 38. ds.

18 Where was disease contracted if not at place of death? (over)

Did an operation precede death? yes. Date of

Was there an autopsy? no. What test confirmed diagnosis? Dept Coroner

(Signed) H. Campbell M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL Jan 2 1925

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE TION is very important. See instructions on back of certificates.

FILM TYPE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93476

D 93476

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Bovam

CITY OF BALTIMORE: (No. 727 Glenwood ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Elizabeth Stockhamm

(a) RESIDENCE NO. 727 Glenwood ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Stockhamm

6 DATE OF BIRTH (month, day, and year) Jan 13th 1885

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dixon Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Walter Stockhamm
(Address) 727 Glenwood ave

15 Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1924, to Dec 29, 1924, that I last saw her alive on Dec 26, 1924, and that death occurred, on the date stated above, at 1015A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

Dec 30, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	12/31/24
20 UNDERTAKER	ADDRESS
Jos. Weber & Son	2503 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each question must be answered. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAKE SIDE

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93477

CERTIFICATE OF DEATH.

10 1-001 D 93477

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 W. Mulberry St. ST.: 19 WARD)

2-FULL NAME Clarence Philip Keckler.

(a) RESIDENCE No. 1307 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Katherine Keckler.

6 DATE OF BIRTH (month, day, and year) Aug 14. 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	4	14	

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work Book keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) Cronhardt Dumler

(c) Name of employer Company.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Keckler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Frances Caroline Gates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Katherine Keckler
(Address) 1307 W. Mulberry ST.

DEC 31 1924 ROBERT A. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1924, to Dec 28, 1924, that I last saw him alive on Dec 28, 1924, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Endocarditis; polyarthritis?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Charles Luther Warner, M. D.

(Address) 3312 Eguton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Dec 31 19 24
20 UNDERTAKER	ADDRESS
Joseph B Cook	1003 W Balto St

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

176599 D 93478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 129 D 93478

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME albert Leonard

(a) RESIDENCE NO. 736 Richmond av Morgantown W. Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Ruth Leonard

6 DATE OF BIRTH (month, day, and year) Sept 20th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) ..... (State or country) W. Va.

PARENTS

10 NAME OF FATHER Henry C Leonard

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Phoebe Grove

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 DEC 31 1924

16 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1924 to Dec 24, 1924 that I last saw h— alive on Dec 24, 1924 and that death occurred, on the date stated above, at 4 45 8 m.

The CAUSE OF DEATH* was as follows:

Uremia, nephritis. (chronic interstitial)

not known.

Symptoms about (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia. Acute pericarditis. about

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No - Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgantown W. Va.

DATE OF BURIAL 12/31 1924

20 UNDERTAKER C. D. Fanning Son - 1936 Lafayette

ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93479

CERTIFICATE OF DEATH.

D 93479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 956 Aisquith ST.; 10 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anton August Winkes

(Residence in Baltimore: No. 956 Aisquith St St., 9/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, September (Month) 29 (Day), 1872 (Year)

7-AGE, 52 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Musician
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Anton Winkes

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Johanna Hammerer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Millea, M.D.

(Address) 1020 N. Calvert St.

15-

DEC 31 1924

ROBERT R. KRAUTER, Registrar.

Dec 31, 191.... Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 30 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 1922, to Dec 30 1924, that I saw him alive on Dec 30 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

Terminal Pneumonia (Duration) yrs. mos. 4 ds.

(Signed) William L. Millea M. D.

Dec 3..., 1924 (Address) 1020 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Jan. 2.., 1925.

20-UNDERTAKER Henry Horn Son — ADDRESS 1301 E. Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21-E.B.R.S.—400 Bks.

Cashier

D 93480 ✓ D 93480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. 11 O.K. 8/1/46 allow D Coroner

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Ward) St. Joseph Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Cashen, Jr.

(a) Residence No. 1830 Rutland Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 26, 1922

7-AGE. 2 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS

10-NAME OF FATHER, Cornelius Cashen Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bridget Ryan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-(Informant) Cornelius Cashen Sr.

(Address) 1830 Rutland ave

15-Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 29, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1924 to Dec. 29 1924

that I last saw h alive on Dec. 29, 1924

and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendicitis

Spreading Peritonitis.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Dec. 28, 1924.

Was there an autopsy? No.

What test confirmed diagnosis? Operation — Appendectomy

(Signed) B. B. Rodes M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL, 19 Dec 31 24

20-UNDERTAKER — ADDRESS

L. A. Weigand 501 E 22 St

N. B.—NAME, ADDRESS, AND OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93481

CERTIFICATE OF DEATH.

145 D 001 93481

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edna K. Smith

1a) RESIDENCE NO. 3201 Westwoodland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of S. Frank Smith

6 DATE OF BIRTH (month, day, and year) June 30th 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	30	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John C Friedel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katherine Shuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Forest ville Balto Co

14 Informant (Address) S Frank Smith 3201 Westwoodland

15 DEC 31 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27th 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1924, to Dec 29, 1924, that I last saw h[illegible] alive on Dec 29, 1924, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Pancreatitis Hyperten-sion Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Cesarean

Did an operation precede death? yes Date of Dec 24, 24.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. F. Leonard, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 2, 1925
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1120 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93482

CERTIFICATE OF DEATH.

8 129

D 93482

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1821 N. Gay St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarette Weinberger

(a) Residence No. 1821 N. Gay St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Weinberger

6-DATE OF BIRTH (month, day and year): May 4 1849

7-AGE: 75 yrs. 7 mns. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:
10-NAME OF FATHER: Unknown.
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Unknown.
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-
(Informant) Julius C. Weinberger Jr.
(Address) 1821 N. Gay St.

15-
DEC 31 1924
ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 19 24 to Dec. 29 19 24
that I last saw h.. alive on Dec 29 19 24
and that death occurred, on the date stated above, at 5.50 P. M.
The CAUSE OF DEATH* was as follows:

Chronic nephritis

probable (Duration) 10 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) uremia
(Duration) .... yrs. .... mos. 3 ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) Edward Hurd, M. D.
, 19 (Address) 26 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Jan 1. 1925

20-UNDERTAKER: Wm. P. Leusel & Son ADDRESS: 811 W. Fayette St.

N. B.—WHITE—Entries must be made in INK and should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Blks.

1924 45 859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93483 D 93483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1926 McCulloh St., 14 Ward) Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith M. Ashby

(a) Residence No. 1926 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Sam'l Ashby

6-DATE OF BIRTH (month, day and year) Oct. 1879

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Frederick Md

PARENTS.

10-NAME OF FATHER Edw Whitney

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Annie E Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Samuel Ashby

(Address) 1926 McCulloh St.

15- Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 29 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1924 to Dec 28 1924

that I last saw h.. alive on Dec 28 1924

and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. B. Hughes M. D.

(Address) 1430 E. Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL, Jan 3 1925

20-UNDERTAKER Clarence E Wright ADDRESS 1364 Kay

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93484

CERTIFICATE OF DEATH.

D 93484

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Hare

(a) RESIDENCE NO 1340 Clipper Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 10/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Jerry Hare

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Esther Hare

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jerry Hare
(Address) 1340 Clipper Rd

15 Filed DEC 31 1924 ROBERT A. KNAUTH Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Culler, M. D.
(Coroner.)

Dec 31/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Freeland (Md) DATE OF BURIAL Jan 1 1925

20 UNDERTAKER Chenowith & Son ADDRESS 36 Reisterstown Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93485

CERTIFICATE OF DEATH.

107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp WARD 23)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Estelle Smith

(a) RESIDENCE NO. 1733 Clarkson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Foster G. Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Preis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Foster G. Smith (Address) 1733 Clarkson St

15 Filed , 19 ROBERT N. KRAUTER, Registrar

DEC 31 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 24 1924, to Dec 30 1924,

that I last saw her alive on Dec 29 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. N. Krauter, M. D.

, 19 (Address) 262 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Jan 1 1925

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1000 Blanks

Death cert. made O.K. by T.O.H. Potter

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93486 CERTIFICATE OF DEATH. 74 D 93486

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rabbi Hymen Ashry

(a) RESIDENCE NO. 2303 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Married

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Ashry

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 53 | Months — | Days — | If LESS than 1 day, ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rabbi

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac M. Ashry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1439 E Balto St

15 Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1924, to Dec. 29, 1924, that I last saw him alive on Dec. 29, 1924, and that death occurred, on the date stated above, at 10.50 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidore S. Jay, M. D.

Dec. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Adrew Brewing Run — DATE OF BURIAL: 12-31-1924

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 93487

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Eden ST., 10 WARD)

2-FULL NAME Mamie Gross

(a) RESIDENCE NO. 518 N Eden ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Geo. Gross

6 DATE OF BIRTH (month, day, and year): March 10, 1879

7 AGE — Years: 45 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): ~~at home~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rockdale Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Geo Gross (Husband) 518 N. Eden St.

15 Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924, to Dec 28, 1924, that I last saw h[illegible] alive on Dec 28, 1924, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

unknown (duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Acute Parenchymatous Nephritis

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Gundry, M. D.

Dec 30 1924 (Address) 1420 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Antrim Cem. — DATE OF BURIAL: Dec 31 1924

20 UNDERTAKER: Thos J. G. Locke — ADDRESS: 1302 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Idaho.

HEALTH DEPARTMENT—CITY OF BALTIMORE

139-002

D 93488

CERTIFICATE OF DEATH.

D 93488

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Abbottson ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Edward Fahs.

(a) RESIDENCE No. 1633 Abbottson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	18 hrs

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Paul Fahs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho. Md.

12 MAIDEN NAME OF MOTHER Mary Fahs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wrightsville Md.

14 Informant George Paul Fahs

(Address) 1633 Abbottson St.

15 Filed DEC 31 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924, to Dec 30, 1924

that I last saw him alive on Dec 29, 1924

and that death occurred, on the date stated above, at 10-15 A.M.

The CAUSE OF DEATH* was as follows:

Morbus Caeruleus

(duration) yrs. mo 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Roscoe E. Cross, M. D.

(Address) 2458 Maryland Ave.

Dec 30 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 31 1924
20 UNDERTAKER	ADDRESS
Johannah Cayoles	1004 Marquith St

Spec.—1-10-21—M&T—1500 Bks.

5.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93489

CERTIFICATE OF DEATH. X 41-006

D 93489

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 N. Mount ST., 15 WARD)

2-FULL NAME Carrie Martin

(a) RESIDENCE NO. 1438 N. Mount ST., WARD Robinson Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S Kirkmore Maryland

PARENTS

10 NAME OF FATHER Henry Stepney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Broadneck Md

12 MAIDEN NAME OF MOTHER Alice Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boone Maryland

14 Informant Hester Martin

(Address) 1438 N. Mount

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27. 1924. to Dec. 28. 1924. that I last saw h alive on 28 December. 1924. and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) John A. L. Lampey, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Robeson a a Md	12/31/24
20 UNDERTAKER	ADDRESS
R E Gross	1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93490

CERTIFICATE OF DEATH.

145- D 93490

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 7 N. Bradford St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Violet Baldwin

(a) Residence No. 7 N. Bradford St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Frederick W. Baldwin

6-DATE OF BIRTH (month, day and year): Feb. 14. 1893

7-AGE: 31 yrs. 10 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Balto
(State or Country): Md.

PARENTS.

10-NAME OF FATHER: Jason Paul

11-BIRTHPLACE OF FATHER (city or town): Balto
(State or Country): Md.

12-MAIDEN NAME OF MOTHER: Wilhelmina Wacker

13-BIRTHPLACE OF MOTHER (city or town): Balto
(State or Country): Md.

14- (Informant) Frederick W. Baldwin
(Address) 7 N. Bradford St

15-

Filed ..... 192.... ROBERT R. KRAMER Registrar.

DEC 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 29. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 19 24 to Dec 29 19 24

that I last saw h[illegible] alive on Dec 29 19 24

and that death occurred, on the date stated above, at 7[illegible] m.

CAUSE OF DEATH was as follows: Mitral Regurgitation following Delivery of Stat Foetus

Child 1 Ja Girl

(Duration) mos. ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) Zoltan Ked M. D.
Dec 29 19 24 (Address) 806 N Wolfe St

State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cat Lawn Cemetery — DATE OF BURIAL: Jan 1. 1925

20-UNDERTAKER: H. Sander Sons — ADDRESS: 1710 East St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93491

CERTIFICATE OF DEATH.

D 93491

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Miller

(a) Residence No. 2122 Druid hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write this word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laber

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER, John Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N C

12-MAIDEN NAME OF MOTHER, Anne Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N C

14-

(Informant) Anna Breese

(Address) 2122 Druid hill

DEC 3 1 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 19 24 to Dec 29 19 24

that I last saw h in alive on Dec 29 19 24

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Diabetis mellitus

Suppurating Diabetic

Gangrene of the Leg

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 10

Was there an autopsy? No

What test confirmed diagnosis? Chem. & Clin Lab

(Signed) Leo Bothert M D

19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Burn DATE OF BURIAL 12/31/24

20-UNDERTAKER, 46 Frost ADDRESS 1405 McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93492

CERTIFICATE OF DEATH.

6 100-001 D 93492

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 W Wolfe St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert R. Blume

(a) Residence No. 129 W. Wolfe St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE, W | 5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 12 1924

7-AGE. yrs. 6 mos. 17 ds. | If LESS than 1 day, hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Joseph Blume

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Theresa Flaherty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Joseph Blume

(Address) 129 W. Wolff

15- Filed ... 192... DEC 31 1924 ... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 19 24 to Dec 30 19 24

that I last saw him alive on Dec 24 19 24

and that death occurred, on the date stated above, at 8/45 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Intussusception Colonic

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lord M. D.

12/30 19 (Address) 1137 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross	December 31 1924
20-UNDERTAKER. Wendell Dyffelsdon	ADDRESS 37 S Dmm

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact stated should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93493

CERTIFICATE OF DEATH.

129 D 93493

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 E. 21st ST., 9 WARD)

2-FULL NAME John C. Doyle

(a) RESIDENCE NO. 515 E. 21 ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Catherine B Doyle

6 DATE OF BIRTH (month, day, and year): Nov. 2-1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
72	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physical Instructor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): NY.

PARENTS

10 NAME OF FATHER: Thomas Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Mrs Catherine B. Doyle

(Address) 515 E. 21 st

15 Filed DEC 31 1924, 19... ROBERT R. KRAUTER, Registrar

Burial Permit Issd.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1924, to Dec 29, 1924, that I last saw him alive on Dec. 28, 1924, and that death occurred, on the date stated above, at 12.20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Diffuse nephritis

Unknown (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical - Chemical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Wyliean - Rustenburg Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Jan 2 1925

20 UNDERTAKER: Chas. E. Franck & Son — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Giacomina Sciacca.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93494

CERTIFICATE OF DEATH.

117 ✓ D 93494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ - Hosp - Balto 24 WARD)

2-FULL NAME Gidcomina, Sciosca

(a) RESIDENCE No. 1712 Johnson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Gidcomina Sciacca.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Albert Di Leonardi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Bridgida Pipitone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vito Di Leonardi

(Address) 1828 E. 27th St

15 Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 28 1924 to Dec 29th 1924

that I last saw her alive on Dec 29th 1924,

and that death occurred, on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows:

Cholecystitis + Appendicitis

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Peritonitis, Paralytic Ileus (duration) yrs. mos. 1 Day

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec 28'24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Alexander Morey M. D.

(Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 1/2/25

20 UNDERTAKER Frank V. Pipitone — ADDRESS 1800 E 32nd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See Instructions on ...

Rev.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93495 — 100-001 — D 93495

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. North Ave & Pulaski, St. Saint Barbaras Home Ward 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Myrtle May Harrison

(a) Residence No. St. Barbaras Home St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 26, 1911

7-AGE.	If LESS than 1 day,
13 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Student

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER. Benjamin Harrison

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Ethel Newell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md.

14- (Informant) Benj F. Harrison (Address) 4 Dolfs Springs. Harford Rd

15- Filed. DEC 31 1924 ROBERT R. CRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 31, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 25 1924 to Dec. 30 1924 that I last saw her alive on Dec. 30 1924 and that death occurred, on the date stated above, at 5.30 Am

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 0 yrs. 0 mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam'n

(Signed) S. A. Dodds M. D.

Dec 31, 1924 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem	Jan 1, 1925
20-UNDERTAKER.	ADDRESS.
Wm J Ricker & Son	North & Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93496

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001
D 93496

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH New Church Jane Hospital

CITY OF BALTIMORE: (No. Annapolis Road. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy May Robinson

(a) RESIDENCE. NO. Annapolis Road. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27/1920

7 AGE — Years: 1 — Months: 9 Weeks — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Charles J Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Helen G. Waterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Helen Robinson
(Address) Annapolis Road

15 Filed DEC 11 1924 ROBERT R. KRAETER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20. 1924. to Dec 30. 1924. that I last saw her alive on Dec 30. 1924. and that death occurred, on the date stated above, at 5.46 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) no yrs. 10 mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lung Sample

(Signed) Raymond P. Ellery M. D.

Dec 31/24

19 (Address) Parkton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: Jan 2 1925

20 UNDERTAKER: Wm J Luckett & Sons

ADDRESS: N & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93497

CERTIFICATE OF DEATH.

90 D 93497

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 Penna Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frank White

(a) Residence No..... 911 Penna St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 12 1897

7-AGE, 27 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watcher

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Frank A White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Rollie Lawson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (Informant) Florence White

(Address) 911 Penna Ave

15-

Filed..... 192.....

ROBERT P. KRAUTER
Registrar

Deputy Public Clerk

MEDICAL CERTIFICATE OF DEATH.

1924

16-DATE OF DEATH (month, day and year). Dec 28

17- I HEREBY CERTIFY, That I attended deceased from Dec 2, 1924, to Dec 28, 1924

that I last saw him alive on Dec 28, 1924

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Vascular disease heart
(Primary)

(Duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical history

(Signed) Frank E. Maynard M. D.

12/31, 1924 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Auburn Lawn DATE OF BURIAL, Dec 31 1924

20-UNDERTAKER, Samuel I Hamsley ADDRESS 3[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93498 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93498

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 E Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Robinson

(a) RESIDENCE No. 1520 E Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Clara M. Robinson

6 DATE OF BIRTH (month, day, and year): March 27 1882

7 AGE: Years 42 | Months 9 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Savanah Ga

PARENTS

10 NAME OF FATHER: John A. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga.

12 MAIDEN NAME OF MOTHER: Laura Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga.

14 Informant: Mrs Clara M. Robinson (wife)

(Address) 1520 E Monument st

15 Filed ..... 19.....

ROBERT R. KRAUTER, Registrar

DEC 31 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 7 1924 to Dec 27 1924,

that I last saw him alive on Dec 27 1924,

and that death occurred, on the date stated above, at 7.06 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension & Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

12/31/1924 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. | DATE OF BURIAL: Dec 31 1924

20 UNDERTAKER: Samuel T Kausler | ADDRESS: 1128 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93499

CERTIFICATE OF DEATH.

74 D 93499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Sarah Ann ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wilcher

(a) RESIDENCE NO. 637 Sarah Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) VA

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ida Bryson (Address) 637 Sarah Ann

15 Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1924, to Dec 29, 1924, that I last saw him alive on Dec 29, 1924, and that death occurred, on the date stated above, at 1:10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) 0 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) none (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of — — —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R R Tenson, M. D.

12, 1924 (Address) 601 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1-2-25

20 UNDERTAKER Dan'l Easton — ADDRESS 9/4

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Rec—12-23-21—E.B.R.S.—400 Blks.

D 93500 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-08 D 93500

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 Woodyear St. 16 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nora Wilson

(a) Residence No. 928 Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9yr. yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Daniel Wilson

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 32 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 10

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Daniel E Wilson

(Address) 928 Woodyear ave

15-

Filed DEC 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 29—24

17- I HEREBY CERTIFY, That I attended deceased from 12—22, 1924 to 12—29, 1924, that I last saw h[illegible] alive on 12—29, 1924, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lagrippe

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank Saunders M. D.

, 19 (Address) 113 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, 1—2—, 1925

20-UNDERTAKER, David Easton | ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93501

100-001

D 93501

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank E. Willis

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1844

7-AGE. 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Showman

(b) General nature of industry, business, or establishment in which employed (or employer). 86

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Indiana

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant). Municipal Hospital Records

(Address).....

15- Filed DEC 31 1924, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-29-24

17- I HEREBY CERTIFY, That I attended deceased from 10-18, 1924 to 12-29, 1924, that I last saw him alive on 12-29, 1924, and that death occurred, on the date stated above, at 5 P.M. The CAUSE OF DEATH* was as follows:

Senile Detonation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Clarence A. Dixon, M. D.

12-31, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL. DEC 31 1924

20-UNDERTAKER. Director of Health.

ADDRESS

Registrar. Wm. R. Woodside

DEC 31 1924

2105

404

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93502

CERTIFICATE OF DEATH.

44 D 93502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 N. Howard ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Duckay

(a) RESIDENCE No 331 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary King

6 DATE OF BIRTH (month, day, and year) May 9-1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
65	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Alps Hotel

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Alexander Buckay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Caroline Harley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. Va.

14 Informant Mary K. Buckay (Address) 331 N. Howard St.

15 DEC 31 1924, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1918, to Dec 30, 1924

that I last saw him alive on Dec 29, 1924

and that death occurred, on the date stated above, at 5.10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Arthritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Malignant Growth Stomach pylorus end. (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Finkbinder M. D.

Dec 31 1924 (Address) 2002 E. Lemmon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 1925
20 UNDERTAKER	ADDRESS
J. B. Hepfer	1850 W. Baltimore St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 93503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 25 + 57

City of BALTIMORE: (No. St. Agnes Hosp. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bernard L. Fuel

(a) Residence No. 622 Frederick Ave St., Ward Catonsville
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Carrie C. Fuel

6-DATE OF BIRTH (month, day and year) June 18, 1892

7-AGE. 33 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Automobile Mechanic 031
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Catonsville Maryland.

PARENTS:
10-NAME OF FATHER. Peter Fuel Do not know
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland " "
12-MAIDEN NAME OF MOTHER. Susie B. Espey "
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland. " "

14- (Informant). Mrs Carrie Fuel
(Address). 622 Frederick Ave

15- Filed DEC 3 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) ~~October~~ Dec. 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from 12-24 1924 to 12-30 1924
that I last saw him alive on 12-30 1924
and that death occurred, on the date stated above, at 12 15 P.M.
The CAUSE OF DEATH* was as follows:

a. Diabetes Mellitus

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) yrs. mos. 4 ds

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) J. Clemens, M. D.
19 (Address) St. Agnes Hosp't.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. — DATE OF BURIAL. Jan 2 1925

20-UNDERTAKER. Easton Sons — ADDRESS. Ellicott City

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93504 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93504

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Buhman

(a) RESIDENCE No. Windsor Court Apt ST., Garrison Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Nellie T. Buhman

6 DATE OF BIRTH (month, day, and year) Jan. 3 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 043

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry C Buhman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Kliff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Nellie T Buhman

(Address) Windsor Court Apt

15 Filed ..... 19.....

Robert P. Harrison,

Burial Permit Clerk

Received

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30/1924

17 I HEREBY CERTIFY, That I attended deceased from 11-11-, 1924, to 12/30/, 1924.

that I last saw him alive on 12/30/, 1924.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Anaemia Chronic Interstitial nephritis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency - Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? K. W. Dolley

(Signed) H. P. Smyth M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Jan 1st 1925

20 UNDERTAKER: Josiah Lyter ADDRESS: 1600 N Monroe Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93505

D 93505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ardene McAllister

(a) RESIDENCE. No. 38 Coldspring Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 4, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	9	27	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John McAllister

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Molly Thompson

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.
(State or country)

14 Informant John H. McAlister
(Address) 38 Coldspring Ave

15 Filed , 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924, to Dec 31, 1924, that I last saw h[illegible] alive on Dec 31, 1924, and that death occurred, on the date stated above, at 8 05 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Tons & Pharyn.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive Nasal Culture

(Signed) Myron B. Tull, M. D.

Dec 31 1924 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Carmel Balto Md

DATE OF BURIAL Jan 2d 1925

20 UNDERTAKER Wm Cox

ADDRESS 502 E Mott

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17165 D 93506

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93506

CERTIFICATE OF DEATH. X 84

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Bertha Bosworth

(a) RESIDENCE NO. Oberlin Ohio ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Edward

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Elgin Ill.

PARENTS

10 NAME OF FATHER: J. McClure

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Fanny Wilder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Dec 31, 1924, that I last saw her alive on Dec 31, 1924, and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor
non-malignant

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? Yes Date of Dec 31

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Tyson, M. D.

(Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oberlin Ohio

DATE OF BURIAL: Dec 31 1924

20 UNDERTAKER: John O. Mitchell

ADDRESS: 1201 W Fayette St

Spec.—1-10-21—M&T—1500 Bks.

1706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93507

D 93507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Sauer

(a) RESIDENCE No. 407 S Smallwood St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Sauer

6 DATE OF BIRTH (month, day, and year) Jan. 28/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Strayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 31 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 - 1924 to Dec 28 - 1924.

that I last saw her alive on Dec 28 - 1924.

and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis following Resection of Stomach for Carcinoma.

(duration) yrs. ... mos 19 ds.

CONTRIBUTORY (Secondary) Resection stomach for Carcinoma

(duration) — yrs. — mos. 19 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec. 10, 24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Julian D Stahl M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Dec 31st 1924

20 UNDERTAKER George L. Schwab ADDRESS 2101 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93508

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2510 Brookfield Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Rachel Myer

(a) Residence No. 2510 Brookfield St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bernhard Myer

6-DATE OF BIRTH (month, day and year) Jany 15th 1847

7-AGE. 77 yrs. 11 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Blumenthal

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Hannah Kaufman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs. J. Myer

(Address) 2510 Brookfield Ave

15- Filed ....., 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

OCT 6 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 31st 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1922, to Dec 30, 1924, that I last saw h[illegible] alive on Dec 30, 1924, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma (rt. Kidney)

Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

, 19 (Address) 736 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Chas Sholom — DATE OF BURIAL, Jany 2 nd, 1925

20-UNDERTAKER, David Sondheim — ADDRESS 118 North Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93509

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 Franklin St. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Virginia Talbott

(a) RESIDENCE NO. 1018 Franklin St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~Married~~, widowed, ~~or divorced~~

~~HUSBAND~~ of (or) WIFE of Benjamin Talbott

6 DATE OF BIRTH (month, day, and year) March 26-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah V. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs B Sta Talbott

(Address) 1018 Franklin St

15 Filed DEC 31 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1924

17

I HEREBY CERTIFY, That I attended deceased from October, 1923, to Dec 31st, 1924, that I last saw her alive on Dec 31st, 1924, and that death occurred, on the date stated above, at 4.18 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Secondary to Epithelioma of Eye

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Epithelioma of Face + right eye (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Talbott M. D.

12/31, 1924 (Address) 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Druid Ridge Cem.	Jan. 2 1925
20 UNDERTAKER	ADDRESS
Wm Cook	1022 E. North Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93510 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93510

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 707 Hollen Rd St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Klug

(a) Residence No. 707 Hollen Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E Klug.

6-DATE OF BIRTH (month, day and year) Dec 28/1838

7-AGE. 86 yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Paving 083

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired

9-BIRTHPLACE (city or town) (State or Country): Germy

PARENTS.

10-NAME OF FATHER: Jacob

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Cowen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11- (Informant) Informant Lillian M. Cowan

(Address) 707 Hollen road.

15- Filed Robert P. Harrison, Registrar.

DEC 31 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 30-1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 20 1923 to Dec 29 1924 that I last saw h. alive on Dec 29 19 24 and that death occurred, on the date stated above, at 5 45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) — yrs. — mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D

Dec 30 1924 (Address) Hamilton Baltimore Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Bal. — DATE OF BURIAL: Jan 1. 5 1925

20-UNDERTAKER: E. Schlosman & Son — ADDRESS 1034 Hanover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93511

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Mulliken ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Birdie Price

(a) RESIDENCE NO. 1409 Mulliken ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 1886

7 AGE — Years: 38 Months: 4 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Methias Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Edn Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Emma Gibbs Sister (Address) 1409 Mulliken st

15 [illegible] 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

JAN 1 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1924, to Dec 29 1924, that I last saw h M alive on Dec 28 1924, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 3 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

12/30 1924 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet cemetery — DATE OF BURIAL: Jan 1 1925

20 UNDERTAKER: Milton Davis — ADDRESS: 745 N Eden

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~173~~ 15 101 Registered No. 001

City of BALTIMORE: (No. 1730 Ellamont St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kennedy Leary

(a) Residence No. 1730 Ellamont St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 31, 1879

7-AGE. 45 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) C & P. Co 009

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Cornelius L. L. Leary

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Rebecca Horton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Harry M. Leary

(Address) 2506 Ellamont St.

15- Filed 1925 192 Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/30/24.

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23 1924 to Dec. 30 1924, that I last saw h~~is~~ alive on Dec. 30 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar. R. Lower. - extending to both lungs. on Dec. 28

(Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. Signs.

(Signed) Wesley Cole M. D.

12/31, 1924 (Address) 2202 Gorsuch

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION ~~OR REMOVAL~~, Lorraine Cemetery — DATE OF BURIAL, 1-1-, 1925

20-UNDERTAKER, John Mitchell — ADDRESS 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

WARGON, RESERVED FOR BINDING.

CANT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93513

CERTIFICATE OF DEATH.

89 D 93513

1 PLACE OF DEATH Womons Hospital

CITY OF BALTIMORE (No. Lafayette & John St. St.; 11 Ward)

REGISTERED No. C

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Henry Brune

(Residence in Baltimore: No. 826 Hamilton Terrace St.; yrs., 66 mos. 5 ds. 15

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 15 th (Day), 1858 (Year)

7-AGE, 66 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... State Employee
(b) General nature of industry, business, or establishment in which employed (or employer)..... State Tax Com.

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER William Henry Brune

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Maryland

12-MAIDEN NAME OF MOTHER Kate C. Nicholas

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert M. Brune

(Address) Baltimore Md

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

JAN 1 1925 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 30 th (Day), 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) angina pectoris

(Duration) yrs. 1 mos. ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

Dec. 31, 1924 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. Greenmount Cem. DATE OF BURIAL, January 2nd, 192

20-UNDERTAKER Henry Jenkins Son & Co. ADDRESS Gilmor & Fayette Sts

Spec—12-23-21—E.B.R.S—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93514

D 93514

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2011 BELAIR ROAD St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPH BALCHUNAS

(a) Residence No. 2011 BELAIR ROAD St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown 1882

7-AGE.	If LESS than 1 day,
41 yrs. 8 mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Lithuania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Lithuania

14- (Informant) Mrs. Kathryn Balchunas
(Address) 2011 Belair Road

15- Filed Jan 1925 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/24/24

17- I HEREBY CERTIFY, That I attended deceased from 12/9/24 19.. to 12/24/24 19..
that I last saw h. alive on 12/24/24
and that death occurred, on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Asthma

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.
, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Holy Redeemer Cem.	Jan 2, 1925
20-UNDERTAKER.	ADDRESS
John A. Greblisunkaup	425 S. Para St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 524 Portland St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Richard G. King

(a) Residence No. 524 Portland St., Ward 22
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) April 3 190[illegible]

7-AGE. 23 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... U.S.Army

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter King

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Liethvania

12-MAIDEN NAME OF MOTHER, Anna Litwin

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), New York

14- (Informant) Peter King

(Address) 524 Portland Street

15- Filed, Jan 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16 1924 to Dec 29 1924

that I last saw him alive on Dec. 29 1924

and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Theodorowsky M. D.

12/30 1924 Address 642 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Janv. 2 1925
20-UNDERTAKER,	**ADDRESS**
John Grebliauckas	1425 S Paca St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93516

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 St. Paul ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Roberts Dill.

(a) RESIDENCE NO. 2231 St. Paul ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta D. Dill.

6 DATE OF BIRTH (month, day, and year) Sept. 21 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auditor

(b) General nature of industry, business, or establishment in which employed (or employer) Lehman Brokerage

(c) Name of employer Society

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Wm. Wallace Dill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Bandle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Henrietta D. Dill

(Address) 2231 St. Paul St.

15 Filed ..... Registrar

JAN 1 - 1925

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to Dec 30th, 1924, that I last saw him alive on Dec 25, 1924, and that death occurred, on the date stated above, at 1:25 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis (chronic)

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) Robert Randall M. D.

Dec 31 1924 (Address) 711 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Jan 1 1925

20 UNDERTAKER H. E. Hughes

ADDRESS 424 N. Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93517 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 1500 Spring St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Grace

(a) Residence No. 1500 Spring St., Ward Stewartstown Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Grace.

6-DATE OF BIRTH (month, day and year) Oct. 2 1847

7-AGE. 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) H&O

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pa

PARENTS.

10-NAME OF FATHER, John Grace

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Sarah Finny

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Sarah A. Grace

(Address) 1500 N. Spring st

15- Filed JAN - 1925 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12-29-24

17- I HEREBY CERTIFY, That I attended deceased from 12/15/24 to 12/29/24 that I last saw h[illegible] alive on 12/29/24 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

6 yrs. 2 mos. 4 ds. (Duration)

CONTRIBUTORY (Secondary) Myocardial Insuff

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? N

Did an operation precede death? N Date of

Was there an autopsy? Chronic Nephr

What test confirmed diagnosis? Chronic Nephr

(Signed) [illegible] M. D.

, 19 (Address) 1500 Brooklyn Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Stewartstown Penna. DATE OF BURIAL. Jan 1 1925

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Harford Ave.

MARGIN RESERVED FOR BINDING.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93518 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93518

CERTIFICATE OF DEATH. Registered No. 9

1-PLACE OF DEATH

City of BALTIMORE: (No. 405 S Castel Street St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy K. Devlin

(a) Residence No. 405 S. Castel Street St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 21 1924

7-AGE. yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William . Devlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Rose . Gorecki

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Mr. William. Devlin
(Address) 405 S. Castel Street

15- Filed 1925 Robert P. Harrison Registrar.

JAN 1 - 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 30/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1924 to Dec 30 1924 that I last saw h[illegible] alive on Dec 30 1924 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
Following Whooping
Cough

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Kaysen M. D.

Dec 31 1924 (Address) 504 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus Cem. DATE OF BURIAL. Jan. 1 1925

20-UNDERTAKER. John M. Weber ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. MARGIN RESERVED FOR INSTRUCTIONS on back of certificates.

CERTIFICATE OF DEATH

Spec- 12-21-21-7 B.R.S.

D 9351

1-PLACE OF DEATH: (No.) 427 S. Parrish St.

2-FULL NAME Wladyslaus . Pruski

(a) Residence No. 427 S. Parrish St., (If

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 31 1924

7-AGE. ....yrs. 4 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country)

10-NAME OF FATHER. Feliks . Pruski

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country)

12-MAIDEN NAME OF MOTHER. Maryanna . Janicki

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country)

14- (Informant) Mrs. Maryanna . Pruski

(Address) 421 S. Parrish Street

15- Filed ....., 192.... Registrar.

Robert P. Harrison,

MEDICAL CERTIFICAT

16-DATE OF DEATH (month, day and year) Dec 31 1

17- I HEREBY CERTIFY, That I attended deceased fr... Nov 1 1924 to DEC 31 192[illegible]

that I last saw h... alive on DEC 31 192[illegible]

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) Damon D. Clay M. D.

, 19 (Address) 336 Haddesfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, Jan 2 192[illegible]

20-UNDERTAKER, John M Weber ADDRESS 803 Bank

In plain writing. Consult it may be properly cleaned. instructions on back of certificate.

Cor.—1-12-21—M&T—100 Bks.

Paul Bocianowski

D 93520

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93520

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3105 Elliott St. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Bocianoski

(a) RESIDENCE NO. 3105 Elliott St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Josephine Bocianowski

6 DATE OF BIRTH (month, day, and year) March 13 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Wagner Canning House
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Josephine Bocianowski
(Address) 3105 Elliott Street

15 Filed ... 1925 ... 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pul. Tuber.
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
(Signed) ..., M. D.
(Coroner)
..., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A.Co.	Jan 2 1925

ADDRESS

20 UNDERTAKER John madeber 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93521 D 93521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 14 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcellus Holmes

(a) RESIDENCE No 2135 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Holmes

6 DATE OF BIRTH (month, day, and year) March 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Stationery
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer
(c) Name of employer 100

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Harry Holmes (son)
(Address) 2135 Druid Hill Ave

15 Filed JAN 1- 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obesity-Cardiac Hypertrophy-
Myocardial Insufficien cy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. L. Porter, M. D.
(Coroner.)

Dec 31/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery — DATE OF BURIAL Jan. 2 1925

20 UNDERTAKER John B. Toadvine — ADDRESS 1027 Fruithill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93522 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93522

CERTIFICATE OF DEATH. 24-001

1-PLACE OF DEATH City of BALTIMORE: (No. Mt Winans Hollins Ferry Rd. St., Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Young

(a) Residence No. Mt Winans, Hollins Ferry Rd. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem. | 4-COLOR OR RACE, el | 5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown 1869

7-AGE, 55 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dom. 0/0
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Edward Grove

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), md.

12-MAIDEN NAME OF MOTHER, Catherine Martin

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), md.

14- (Informant) Mrs. Veronica Levy
(Address) Mt. Winans Md.

15- Filed ..... 192 Robert F. Harrison, Registrar.
1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/29/24

17- I HEREBY CERTIFY, That I attended deceased from 12/28/24 19.. to 12/29/24 19.. that I last saw h.. alive on 12/29/24 19.. and that death occurred, on the date stated above at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Duration yrs. 6 (History) mos. ds.

18-Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Conley, M. D.

12/31, 19 24 (Address) 908 Shoop Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery | DATE OF BURIAL, Jan 1, 19 25

20-UNDERTAKER, John H. Todini | ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93523

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH
City of BALTIMORE. (No. 615 Joseph de'all St. 22 Ward)

Registered No.....

2-FULL NAME... 615 Joseph de'all

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No.... 615 Joseph St., 22 Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, Col
5-Single, Married, Widowed, or Divorced, (Write the word.) Married
5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliza Deall
6-DATE OF BIRTH (month, day and year) unknown
7-AGE, 46 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.
8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer....
9-BIRTHPLACE (city or town) (State or Country), Jamaica B.W.I.

PARENTS.
10-NAME OF FATHER, unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Jamaica
12-MAIDEN NAME OF MOTHER, unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Jamaica

14-
(Informant) Eliza Deall
(Address) 615 Joseph St.

15-
Filed 5 1925
Registrar.

JAN 1 - 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/29/24

17- I HEREBY CERTIFY, That I attended deceased from 11/23/24 to 12/29/24
that I last saw h... alive on 12/28/24
and that death occurred, on the date stated above, at 6.30 A. M.
The CAUSE OF DEATH* was as follows:
Mitral Regurgitation & Dilatation of Heart (Duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Alcoholism Probably Syphilitic (Duration) ! yrs. mos. ds.
18-Where was disease contracted if not at place of death? none
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Geo. Burley, M. D.
12/30, 19 (Address) 905 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, 1/1, 1925
20-UNDERTAKER, John K. Tadvin — ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93524

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bridelia Cronin

(a) RESIDENCE. No. Lisquette St. ; Oakland Ave ST., WARD. Mt. Savage Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec - 26 - 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
66		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Francis Cronin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Forde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Mary Dionysia
(Address) Lisquette St., City

15 Filed ....., 19 .....
Registrar

Robert F. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 30 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1924, to Dec 30, 1924, that I last saw h[illegible] alive on Dec 27, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Abdominal

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 15, 24

Was there an autopsy? For obstruction due to growth

What test confirmed diagnosis?

(Signed) F. J. Kirby, M. D.

Dec 31, 1924 (Address) 1110 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenstown Private	Jan 1 1925
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 E Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93525

D 93525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Morris H Amsan ST., 13 WARD)

2-FULL NAME Morris H Amsan

(a) RESIDENCE NO. 2524 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Rose Amsan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Lail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balt St

15 Filed JAN 1 1925, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Dec 30, 1924, that I last saw h/m alive on Dec 30, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

3 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis Arteriosclerosis

Senile Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Longhenry M.D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Sholom Cem

DATE OF BURIAL Jan 2 1925

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 132 Overland ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Jolles

(a) Residence No. 132 Overland ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Simon Jolles

6-DATE OF BIRTH (month, day and year) ?

7-AGE, Yrs. 66 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Abraham Jolles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Leah Jolles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14- (Informant) Jack Lewis

(Address) 1439 E. Balto Street

15- Filed JAN 1 1925, 192.... Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1924, to Dec 31, 1924

that I last saw h.. alive on Dec 31, 1924

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis + oedema of lungs

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? N Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz M. D.

1-1, 1925 (Address) 2040 Eaton St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Hebrew Cem.	Jan 1, 1925
20-UNDERTAKER.	**ADDRESS**
Jack Lewis 1439	E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93527 HEALTH DEPARTMENT—CITY OF BALTIMORE -D 93527

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Royalton Apt (Md. & North St. Ave 12 WARD)

2-FULL NAME Virginia Caroline Caldwell

(a) RESIDENCE NO. Royalton Apt. ST., ... WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 86 yrs. 3 mos. 4 ds.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Caldwell

6 DATE OF BIRTH (month, day, and year) Sept. 27-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer ..... None

9 BIRTHPLACE (city or town) Salisbury
(State or country) Md.

PARENTS

10 NAME OF FATHER Zuddia Williams

11 BIRTHPLACE OF FATHER (city or town) Salisbury
(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Travers

13 BIRTHPLACE OF MOTHER (city or town) Salisbury
(State or country) Md.

14 Informant Mrs H.B.Applewhaite (daughter)
(Address) 2209 Elsinor Ave-Walbrook

15 Filed JUN 1 1925, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1924, to Dec 30, 1924, that I last saw h alive on Dec 30, 1924, and that death occurred, on the date stated above, at 4 20 A.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) ..... yrs. ..... mos. 27 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) John S. Bishop, M. D.

, 19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL June 2 1925

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Walbrook Apts. St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sargent Wright

(a) Residence No. Walbrook Apts. St., Ward Greenwich Conn.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Dec-3-1923

7-AGE, 1 yrs. 0 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) Greenwich (State or Country), Conn

PARENTS.

10-NAME OF FATHER, Harry H. Wright

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary A. Owen

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Maryland

14- (Informant) H. H. Wright (Father) (Address) Walbrook Apts.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

JAN 1 - 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec-31-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 21, 19 24 to Dec 31, 19 24

that I last saw him alive on Dec 31, 19 24

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

~~Chronic Nephritis~~

Bronch Pneumonia

(10 days) Tuberculosis - 36 hrs.

(Duration) ....yrs. ....mos. 1 0 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. ....mos. 28 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Carroll Lockard, M. D.

Jan 1, 1925 (Address) 4 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cemetery DATE OF BURIAL, Jan 2 19 25

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou...
in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO...
instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93529

CERTIFICATE OF DEATH.

24-001

24 D 93529

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Fulton Ave. St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Barrett Phelps

(Residence in Baltimore: No. 415 N. Fulton Ave St.; about 66 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Mar (Month) ..... 24 (Day), 1864 (Year)

7-AGE, 60 yrs. 9 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James J. Barrett

11-BIRTHPLACE OF FATHER (State or Country) London, England

12-MAIDEN NAME OF MOTHER Catherine Carroll

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Barrett

(Address) 415 N. Fulton Ave

15-

Filed JAN 1 - 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) ..... 31st (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1924, to Dec 31st, 1924, that I saw her alive on Dec 30th, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis .....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 2 hrs.

(Signed) ..... E. Ann T. Summers ..... M. D.

Dec 31, 1924 (Address) 538 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Jan 2, 1925

20-UNDERTAKER, Joseph F. Cook

ADDRESS 803 W. Pratt St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93530 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 203 N. Carey Street St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Aurelia Mobley

(a) Residence No. 203 N.Carey Street St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry H.Mobley

6-DATE OF BIRTH (month, day and year): June 29,1857

7-AGE: 67 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Emmitsburg, Maryland.

PARENTS.

10-NAME OF FATHER: John Hoover

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederick County Maryland

12-MAIDEN NAME OF MOTHER: Ann Knouff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Frederick County Maryland

14- (Informant): Harry H.Mobley

(Address): 203 N.Carey Street

15- Filed JAN 1 1925 19 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 30,1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 27, 19 24 to Dec 30, 19 24

(that I last saw h[illegible] alive on Dec 30, 19 24,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Dr. Kalm, M. D.

12-31 19 24 (Address) 3005 W.North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jan 3rd 19 25

20-UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 93531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93531

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

City of BALTIMORE: (No. 1727 St Paul St. 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Collier

(a) Residence No. 1727 St. Paul St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm H. Collier

6-DATE OF BIRTH (month, day and year) Aug 30/44

7-AGE. 80 yrs. ..... mos. ..... ds.

If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS

10-NAME OF FATHER, Wm P. Stickberry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Ray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14 (Informant) Mrs. Collier

(Address) Easton Md

15- Filed 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 28-24

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 1924 to Dec. 31 1924

that I last saw her alive on Dec 31 1924

and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Dysfunction of Age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. L. Kilgallen M. D.

19 (Address) Cathedral & Mulberry Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Easton Md

DATE OF BURIAL Jany 2, 1925

20-UNDERTAKER, John O. Mitchell

ADDRESS 201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Clarence Snyder D 93532

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 731 McCabe Ave ST., (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel N. Snyder

(a) RESIDENCE No. 731 McCabe Ave ST., WARD Charlestown W. Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE~~ Harriet A Snyder

6 DATE OF BIRTH (month, day, and year) March 31 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Samuel Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Cynthia Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Burwell C Snyder

(Address) 731 McCabe Ave

15 Filed ....., 19 Robert P. Harrison, Registrar

JAN 1 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 24

17 I HEREBY CERTIFY, That I attended deceased from July 7 , 1924 to Dec 31 , 1924 that I last saw him alive on Dec 29 , 1924 and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Jefferson Co W Va

Did an operation precede death? Date of Jan 16 24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo. Waller M. D.

(Address) 1 E Centre St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown. W. Va. DATE OF BURIAL 1-1 1925

20 UNDERTAKER E & B Harlr ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93533 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 93533

CERTIFICATE OF DEATH.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1914 Braddish Ave 5 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edw. Osbourn

(a) Residence No. 1914 Braddish Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 3 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary P. Osbourn

6-DATE OF BIRTH (month, day and year) Sept 14, 1841

7-AGE. 83 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bookkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Baltimore Md

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, John Fredk Osbourn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Miriam Arrowsmith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N.Y.

14- (Informant) Mrs Miriam A Gray

(Address) 1917 Braddish Ave.

15- Filed JAN 1 1925, 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 31, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23rd, 1924, to Dec. 31st, 1924, that I last saw him alive on Dec 31st, 1924, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 9 ds

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation.

(Signed) Wm Howard Baker, M. D.

, 19 (Address) 1905 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cem	Jan. 2, 1925

20-UNDERTAKER. Wm Pickuel Sons ADDRESS Mortuary Pa

Spec.—1-10-21—M&T—1500 Bks.

D 93534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93534

CERTIFICATE OF DEATH.

101-6

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Cold Spring Ave ST. 27 WARD)

2-FULL NAME Catherine R. Morgan

(a) RESIDENCE NO. 30 Cold Spring Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Morgan

6 DATE OF BIRTH (month, day, and year) Jan 8-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	45	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Andrew Bohle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Deist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Conrad Bohle
(Address) Highlandtown

15 Filed JAN 1 1925 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Dec 29, 1924, that I last saw h alive on Dec 29, 1924 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) Clarence Dennis M. D.

(Address) 4208 Norfolk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz bem	Jan 2 1925
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	N Y Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93535

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 83

City of BALTIMORE: (No. 2039 W North ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Ball

(a) Residence No. 2039 W North ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of April 1848

6-DATE OF BIRTH (month, day and year) Oct 11 1848

7-AGE. 76 yrs. 2 mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Candy Maker 086

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer. Retired

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Sophia Schmuck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Tom Constantine

(Address) 2039 W North ave

15- Filed. 1925 192 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 30 24

17- I HEREBY CERTIFY, That I attended deceased from several months 19 to Dec 30 19 24

that I last saw him alive on Dec 29 19 24

and that death occurred, on the date stated above, at 7.35 a m.

The CAUSE OF DEATH* was as follows: "Softening of the brain" seems to till if best probably due to tumor. No history of apoplectic attack. Mental derangement noticed for last 3 months. No family history as cause.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) X

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? None special

(Signed) O. H. Hoffman M. D.

12-31-1924 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Jany 2 19 25

20-UNDERTAKER. J. Pierce & Son ADDRESS North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93536

D 93536

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 1925 E Eager St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Skarda

(a) Residence No. 1925 E. Eager St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Skarda

6-DATE OF BIRTH (month, day and year) Dec 22 1882

7-AGE. 42 yrs. mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS

10-NAME OF FATHER, George Skarda

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) Marie Skarda

(Address) 1925 E Eager St

15- Filed JAN 1 1925 By Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 30/24

17- I HEREBY CERTIFY, That I attended deceased from 12-28 19 24 to Dec 30 19 24

that I last saw him alive on Dec 30 19 24

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Hugh Brooks M. D.

(Address) 1525 Eutaw Pl Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL Jan 2 1925

20-UNDERTAKER, Frank Crockson — ADDRESS Middle Branch

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93537

HEALTH DEPARTMENT—CITY OF BALTIMORE

1881-08 D 93537

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Sykir

(a) RESIDENCE No 2529 E. Madison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sykir

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John Zamrzla
(Address) 2529 Madison St

15 Filed JAN 1 - 1925, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- struck by Automobile

(Inquest Jan 5/25)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Hollander, M. D. (Coroner.)

1-1-25, 192 (Address) 708 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 2 1925
20 UNDERTAKER	ADDRESS
Frank Enoch & Son	1906 Gobler

Spec.—1-10-21—M&T—1500 Bks.

D 93538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93538

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 Foster Ave ST., 1 WARD)

2-FULL NAME Joseph Wisniewski

(a) RESIDENCE NO. 2402 Foster Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 52 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Michalina Wisniewski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer — 040

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Barbara Tomiczka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rosie Sadlack (Address) 2402 Foster Ave

15 Filed JAN 1 - 1925, 19 .....

Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1924, to Dec 30, 1924.

that I last saw h[illegible] alive on Dec 28, 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Complete Obstruction

(duration) .... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Hypertrophy

(Signed) Samuel Feinberg, M. D.

19 (Address) 1528 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Jan 2, 1925
20 UNDERTAKER	**ADDRESS**
M. J. Sadowski	405 S. Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93539

CERTIFICATE OF DEATH.

90

D 93539

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 416 Robert St ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Brown

(a) RESIDENCE. NO. 416 Robert St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm Brown

6 DATE OF BIRTH (month, day, and year) October 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bucks Md

PARENTS

10 NAME OF FATHER Frederick Horn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie L. Gregory

(Address) 416 Robert St

15 Filed JAN 1 - 1925 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/19/23, 19 23, to death, 19 24.

that I last saw her alive on Nov 7, 19 24

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Dilated and Valvular Heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm H Beasley, M. D.

19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	1/1/1925
20 UNDERTAKER	ADDRESS 518
Samuel Hemsley & Bro	W Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 93540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 21 Ward) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wolf

(a) RESIDENCE No. 844 Rhynhart St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or... min.
	49	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER John Wolf.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER ?.

13 BIRTHPLACE OF MOTHER (city or town) Balto,
(State or country)

14 Informant Municipal Hospital Records
(Address) Robert P. Harrison,

15 Filed JAN 7 1925, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1924, to 12-29, 1924, that I last saw him alive on 12-29, 1924, and that death occurred, on the date stated above, at 8²⁰ P. m.

The CAUSE OF DEATH* was as follows:

Progressive Central Muscular Atrophy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sx. & Autopsy

(Signed) Claude G. Howard, M. D.

12-31, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 2. 1925
UNDERTAKER Edward J. Howard & Son	ADDRESS 90 Holliday
per Edward J. Howard	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-09 D 93541

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2640 E. Monument ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Caine

(a) RESIDENCE No. 2640 E. Monument ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Solomon Caine

6 DATE OF BIRTH (month, day, and year): Feb 14 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Francis O'Neil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine O'Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John J Caine

(Address): 2640 E Monument st

15 Filed JAN 1 1925, 19 ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 19 24, to Dec 30, 19 24,

that I last saw her alive on Dec 30, 19 24,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Femoral arteris - Atheroma

..... (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Cardiac failure - Old age

..... (duration) ..... yrs. ..... mos. .....

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm J Schultz, M. D.

Dec 29 1924 (Address) 701 Hanover Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jany 2 1925
20 UNDERTAKER	ADDRESS
Robt J Turner	N. Eutaw

Cor.—1-12-23—M&T—100 Bks.

D 93542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93542

CERTIFICATE OF DEATH.

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Clinton St ST., No WARD)

2-FULL NAME Hillsaw Cox

(a) RESIDENCE No 1617 S Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Collard

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer 048
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Peary Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Mary James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Sarah Cox
(Address) 1617 Clinton St

15 Filed Jan 1 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) 1 yrs. mos. ds.

(Signed) C C Childs, M. D.
(Coroner.)
1/2/25, 192 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edenton North Carolina	1/1/25 192
20 UNDERTAKER	ADDRESS
R B Grant	1405 McElderry St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 93543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Cider Al ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Whitaker

(a) RESIDENCE NO. 634 Cider Al ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. 6 ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year) Dec 23rd 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
48			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: unknown

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore Md

12 MAIDEN NAME OF MOTHER: Walter Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore Md

14 Informant (Address): Laura Bruce 634 Cider alley

15 Filed ..... 19 ..... Registrar

JAN 1 - 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 25 1924, to Dec 29 1924, that I last saw him alive on Dec 29 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary): none

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical

(Signed) R B Young on M. D.

30 19 24 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 1 1925
20 UNDERTAKER	ADDRESS
Jno Scott Hooper	208 W. Conway St

Spec.—1-10-21—M&T—1500 Blks.

D 93544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93544

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 4 WARD)

2-FULL NAME Cora Myers

(a) RESIDENCE NO. 126 E. Chesapeake ave. Towson ST., ... WARD Towson.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~X~~ yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Myers

6 DATE OF BIRTH (month, day, and year): July 4- 1900

7 AGE: Years: 24; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore County. Md.

PARENTS

10 NAME OF FATHER: Grant Bass

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Georgiana Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Long Green Baltimore Co. Md.

14 Informant: James Myers.
(Address) 126 E. Chesapeake ave. Towson Md.

15 Filed JAN 1 - 1925, 19... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/31 12 AM, 192X, to 12/31 (8:45 AM), 19 24,

that I last saw him alive on Dec 31, 192X,

and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

Shock (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Atrophic Placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Douglass M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Hill Cemetery Towson

DATE OF BURIAL: Jan 2 1925

UNDERTAKER: Wm B. A. Elliott

ADDRESS 1765 Ashland Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

TYPE

Spec.—1-10-21—M&T—1500 Bks.

D 93545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

D 93545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 11 WARD)

2-FULL NAME. Annie Williams

(a) RESIDENCE No. 443 Little Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 631

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Alice Elliott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Municipal Hospital Records (Address)

15 Filed JAN 1 - 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-27, 1924, to 12-31, 1924, that I last saw her alive on 12-31, 1924 and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid
& Secondary Metastases

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Dixon, M. D.

12-31 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 2 1925

20 UNDERTAKER: Mrs. P. G. Elliott — ADDRESS: 1727 Eutaw Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be filled in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

DARK

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer must be full and complete. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D 93546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 001 ✓ D 93546

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N. Caroline ST., 10 WARD)

2-FULL NAME Lavinia Davis

(a) RESIDENCE No. 709 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0 10

9 BIRTHPLACE (city or town) (State or country): V. C.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs R. G. Elbert

(Address) 1125 Ashland Av

15 Filed , 19 Robert P. Harrison, Registrar

JAN 1 - 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-30 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-29. 1924. to 12-30. 1924.

that I last saw her alive on 12-30. 1924.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. H. Barnett, M. D.

1-1-1925 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — DATE OF BURIAL: Jan 3 1925

20 UNDERTAKER: Mrs R. G. Elbert — ADDRESS: 1125 Ashland

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mount Hope Retreat St. 28th Ward) 1

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rev. Edward V. Higgins

(a) Residence No. Mount Hope Retreat St., 28th Ward New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 66 yrs. 11 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 21st 1859

7-AGE. 65 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Religious- Priest R. Catholic

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work

(c) Name of employer.....

9-BIRTHPLACE (city or town) New York city (State or Country), New York -

PARENTS.

10-NAME OF FATHER Edward Higgins

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Cronin

13-BIRTHPLACE OF MOTHER (city or town) New York city (State or Country),

14- (Informant) Records of Mt Hope

(Address) Mt Hope Baltimore

15- Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 1st 1925

17- I HEREBY CERTIFY, That I attended deceased from January 16 1925 to Jan 1st 1925, that I last saw him alive on Jan 1st 1925, and that death occurred, on the date stated above, at 11.20 A.M. The CAUSE OF DEATH* was as follows:

Arteria Sclero - Cerebri Post

Volvulus -

(Duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Delusional Psychosis -

Abt (Duration) 10 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? New York city -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery M. D.

Jan 1st, 1925 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New York City - DATE OF BURIAL, Jan 1 2 19....

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary Registered No. 9

City of BALTIMORE: (No. 1820 Eastern Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. George Poisal

(a) Residence No. 1820 Eastern St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Flora M Poisal

6-DATE OF BIRTH (month, day and year) Feb 2-1882

7-AGE. 42 yrs. 10 mos. 29 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Elevator Operator

(b) General nature of Industry, business, or establishment in which employed (or employer). Church Home Inf.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER Michael Poisal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Elizabeth Watts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), W. Va

14- (Informant) Raymond B Poisal

(Address) Gulliton P.O. Md

15- Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 31, 19 24, to Dec 31, 19 24

that I last saw him alive on Dec 31 19 24

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Keith C. Rice M. D

19 (Address) Church Home & Inf

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, Jan 3, 1925

20-UNDERTAKER Wm. Cook ADDRESS 3328 Gough Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

D 93549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93549

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. William) University Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Minnie Martin

(a) RESIDENCE NO. 1037 Walden St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris H. Martin

6 DATE OF BIRTH (month, day, and year) June 10. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Morris Moyer
(Address) 1037 Walden St

15 Filed DEC 2 - 1925 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) a few hours

CONTRIBUTORY (Secondary) accidentally Felon's Shot

(duration) yrs. mos. ds.

(Signed) W. H. Jones, M. D.
(Coroner.)

12. 31, 192 (Address) 1131 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., 1 ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1037 Walden St

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Dr Peters — Jan 2 1925

20 UNDERTAKER — ADDRESS

Wm Cook — 3028 Fait Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 11 23550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 B 93550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Nora Sweeze

(a) RESIDENCE No. 24 S. Spring ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	-	-	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1924, to Dec 31, 1924.

that I last saw her alive on Dec 31, 1924,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis (Gumma of naso pharynx) & secondary infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Larynx.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 12-30-24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm. Baetjer, M. D.

Jan 1, 1925 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan. 3 19 25
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	416 N. Caroline

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93551

CERTIFICATE OF DEATH.

+122-001 D 93551

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Allen Gatewood

(a) RESIDENCE NO. Washington DC ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer) 647
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jonas Gatewood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER M. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JAN 2 - 1925 19 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1924, to Dec 31, 1924, that I last saw him alive on Dec 31 (—), 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pickes Disease
Polyserositis
Mediastinitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Warfield M. Firor, M. D.

Jan 1, 1925 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL Jan 9 1925

20 UNDERTAKER Chris H. Johnson & Co ADDRESS 57 N. Caroline

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 93552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93552

CERTIFICATE OF DEATH.

X 274 1001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hospital (Quarantine) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hans Renne Hansen

(a) RESIDENCE NO. U S Marine Hosp. ST., WARD New York.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie C.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sea Captain
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Norway
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Minnie C. Hansen
(Address) 352 16th St Brooklyn N.Y.

15 Filed JAN 2 - 1925, 192 ROGER R. KRAUTER
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Jno. H. Bowman, M. D.
(Coroner.)
Jan 5 192 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York N.Y.

DATE OF BURIAL Jan 7 192 5

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93553

D 93553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 71 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Shulman

(a) RESIDENCE NO. Washington D.C. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER ~~Alexander~~ Shulman

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Protsatsky

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Meyer Shulman
(Address) 3304 M St Washington D.C.

15 Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1924, to Jan 2, 1925, that I last saw him alive on Jan 2, 1925, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 2 days

CONTRIBUTORY (Secondary) Pulmonary Abscess

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Dec. 23, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Isidor H. Fry M. D.

Jan. 1925 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~Hebrew~~ Washington D.C. DATE OF BURIAL 1/2 25 1925

20 UNDERTAKER Sol Levin & Bro ADDRESS 112 E Belto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93554

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 18 WARD)

2-FULL NAME Gethro Turner

(a) RESIDENCE No. 1005 W Lexington St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carthage (State or country) North Carolina

PARENTS

10 NAME OF FATHER Alexander Turner

11 BIRTHPLACE OF FATHER (city or town) Carthage (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Alice Marshall

13 BIRTHPLACE OF MOTHER (city or town) Carthage (State or country) North Carolina

14 Informant Mrs. R. Turner (Address) 1005 W. Lexington St

15 Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924, to Dec 30, 1924, that I last saw h in alive on Dec 30, 1924, and that death occurred, on the date stated above, at 430 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Stain Bacilli

(Signed) W Wallace Walker M. D.

, 19 (Address) University Hospital Lombard & Greene Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-2-1925

20 UNDERTAKER David Easton

ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93555

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 93555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1033 Wilmot St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Haywood

(a) Residence No. 1033 Wilmot St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-Single, Married, ~~Widowed~~ or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. ..... mos. ..... ds.

If LESS than 1 day. ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Va.

PARENTS.

10-NAME OF FATHER. David Lavor

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Danville Va

12-MAIDEN NAME OF MOTHER. Ann Lavor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Danville Va

14- (Informant) Miss Florence Holmes

(Address) 1023 Madison ave

15- Filed ..... 192.. EUGENE B. KRAUTER, Registrar.

JAN 2 - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/30/24

17- I HEREBY CERTIFY, That I attended deceased from 12/30, 1924 to 12/30, 1924, that I last saw her alive on 12/30, 1924, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) H. Peters, M. D.

, 19 (Address) 200 Penn Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn cem	1-2-25
20-UNDERTAKER. Daniel Easton	ADDRESS 911 Ea ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93556

CERTIFICATE OF DEATH.

D 93556

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

2-FULL NAME Garrison Tate

(a) RESIDENCE NO. 614 S. Mulberry st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Ephriam Tate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Clara Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1924, to Dec. 31, 1924, that I last saw him alive on Dec. 31, 1924, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) J. O. White, M. D.

12-31, 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-25-25

20 UNDERTAKER Dan'l Easton

ADDRESS 916 6th ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93557
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 Little Wilson St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Cromwell

(a) Residence No. 1113 Little Wilson St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-Single, Married, Widowed, or Divorced (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1902

7-AGE: 22 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va.

PARENTS:
10-NAME OF FATHER:
11-BIRTHPLACE OF FATHER (city or town) (State or Country):
12-MAIDEN NAME OF MOTHER:
13-BIRTHPLACE OF MOTHER (city or town) (State or Country):

14-
(Informant): Mrs Cromwell
(Address) 1113 Little Wilson

15-
Filed 1925 ROBERT R. KRAUTER Registrar.
JAN 2 - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 29 24

17- I HEREBY CERTIFY, That I attended deceased from December 27 1924 to December 29 1924
that I last saw her alive on December 29 1924
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs
Tuberculosis
(Duration) yrs. mos. 1 d.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (Duration) yrs. 7 mos. 10 d.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr L W Kennard M. D
12-30 1924 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-2-1925
20-UNDERTAKER	ADDRESS
Jno T Corbett	916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

D 93558

CERTIFICATE OF DEATH.

D 93558

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3743 Resterstown Rd St., 13-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Enoffsky

(a) Residence No. 3743 Resterstown Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 21 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Enoffsky

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Baresh Fish

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Shandel M.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Bariel Fish

(Address) 3743 Resterstown Rd

15-

Filed 192 ROBERT H. KRAUTER Registrar.

JAN 2 - 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 1-25

17- I HEREBY CERTIFY, That I attended deceased from July 1924 to Jan 1 1925

that I last saw her alive on Jan 1 19

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary) acute dilatation of Heart (Duration) yrs. mos. 1 ds

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Fredericks Lotz M. D

1-1 1925 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, Jan 2 19 25

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Sec. 1 10-31 M&T 1500 Blks.

D 93559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93559

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST. 6-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Aganowitz

(a) RESIDENCE NO. 1402 N. Washington St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mendel Aganowitz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mendal —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 Eldbert

15 Filed JAN 2 - 1925 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/1/25 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 19 24 to Jan 1 19 25

that I last saw her alive on Jan 1 19 25

and that death occurred, on the date stated above, at 8-40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach (?) (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Philip Jacobson M. D.

, 19 (Address) Hellman Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmen Circle Cem DATE OF BURIAL Jan 2 19 25

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eldbert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93560

CERTIFICATE OF DEATH.

1825 D 93560

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp ST., 1 WARD)

2-FULL NAME John W. Sachs

(a) RESIDENCE NO. 731 S. Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Sachs

6 DATE OF BIRTH (month, day, and year) April 16/76

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bot Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Southern Can Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary V. Sachs
(Address) 731 S. Glover st

15 Filed JAN 2 - 1925, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (Base) accidental
(Fell down stairs at Southern Can Co) Dec 26/24)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism (duration) yrs. mos. ds.

(Signed) J. T. Wooten, M. D. (Coroner.)

1/1/25, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL Jan 2 1925

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2022 E. Hoffman ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian J. Crist

(a) RESIDENCE NO. 2022 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Norman L. Crist

6 DATE OF BIRTH (month, day, and year): Mar 27/04

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John B. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma L. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Norman L. Crist

(Address): 2022 E. Hoffman

15 Filed JAN 2 - 1925 AUGUST H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/31 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924 to Dec 31, 1924.

that I last saw her alive on Dec 31, 1924;

and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 302 N Ellwood

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) Edward J. Levitt, M. D.

1/1, 1925 (Address) 413 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 1/3 1925

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

M D 93562

CERTIFICATE OF DEATH.

1 29 D 93562

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

2-FULL NAME Emma Jones

(a) RESIDENCE NO. 550 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Jones

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cut

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 19-24

17

I HEREBY CERTIFY, That I attended deceased from Dec 18, 1924, to Dec 31, 1924.

that I last saw h[illegible] alive on Dec 31, 1924,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

Uremia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Warfield M. Firor, M. D.

Jan 1, 19 25 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-3 1925
20 UNDERTAKER George T. A. Gibson	ADDRESS 1735 Mosher

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93563

CERTIFICATE OF DEATH.

D 93563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Jefferson ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Stewart.

(a) RESIDENCE NO. 1423 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colord	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER robert o Carpenter

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Un. Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant albert stewart
(Address) 1420 Jefferson st

15 Filed JAN 2 1925 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-1924

17

I HEREBY CERTIFY, That I attended deceased from 12-19-1924, to 12-30-1924, that I last saw h-r alive on 12-30-1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. H. Carnegie, M. D.

1-1-1925 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL Jan 2. 1925

20 UNDERTAKER Edward Bryson — ADDRESS 1681 orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WARNING—DETACHED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 93564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93564

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 N. Montford ST. Ave WARD)

2-FULL NAME Frank Embot.

(a) RESIDENCE No. 210 N. Montford ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Unknown. about 75.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer) at Garage.

(c) Name of employer Geo. L. Norris.

9 BIRTHPLACE (city or town) (State or country) Chas. Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Catherine Brown.

(Address)

15 Filed JAN 2 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Dec 31, 1924, that I last saw him alive on Dec 26, 1924, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Bronchs-Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Dundalk. Md.

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McLarmie M. D.

, 19 (Address) Dundalk. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North Forest Burial gard W.L. Church

DATE OF BURIAL Jan 4 1925

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93565

CERTIFICATE OF DEATH.

122 -001
122 D 93565

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Bennett Place ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Young—

(a) RESIDENCE NO. 1014 Bennett Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Miller Young

6 DATE OF BIRTH (month, day, and year): Feb 17 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Produce

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Godfred H. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. Young (Address) 1014 Bennett Place

15 Filed JAN 2 - 1925 19.. ADELAIDE R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 24 1924 to Dec 30 1924 that I last saw him alive on Dec 25 1924 and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contusion of Liver

Chronic Nephritis

Varicose veins of Leg

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbuncle Lumbar Region

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. C. Young — M. D.

(Address) 617 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 1-2 1925

20 UNDERTAKER: H. Brenning Son

ADDRESS 517 N Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93566

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 East 27th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jacob Noah

(a) Residence No. 616 East 27th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) January 12 1852

7-AGE. 72 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ship Calker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, George Noah

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Mary Lechner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Henry Noah

(Address) 616 East 27th

15- Filed JAN 2 - 1925 MYRTLE R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 19-24 19.. to Dec 29 19..

that I last saw h wife on Dec 29 19..

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick M Summers M. D.

Jan 2 - 1925 (Address) 1710 E. 32nd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, January 2 1925

20-UNDERTAKER. Wendell Oppel & Son — ADDRESS 37 S Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 93567

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D 93567

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1206 Franklin Rd St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Sumner

(Residence in Baltimore: No. 1206 Franklin Rd St.; 5 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: January (Month) 6 (Day) 1857 (Year)

7-AGE: 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Howard Co Md

PARENTS

10-NAME OF FATHER: Wm Joyce

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Mary Reynolds

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sophia Holland

(Address) 1206 Franklin Ave St

15- Filed ..... 191 .....

ROBERT R. KRAUTER
Chief Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. (Month) 30 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1924, to Dec. 30th 1924, that I saw h-- alive on Dec. 30th 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Myocarditis

(Duration) 6 yrs ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) Frank J. Hillegeas M. D.

Jan 2nd 1925 [Address] 2838 Elmora Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Calvary Cem — DATE OF BURIAL: Jan 2 1925

20-UNDERTAKER: Samuel H Grady — ADDRESS: 578 W Baltimore St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93568

CERTIFICATE OF DEATH.

90 D 93568

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Hammelton Terrace 11-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud T. Perrin

(a) RESIDENCE NO. 813 Hammelton Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) August 12th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria (State or country) Virginia

PARENTS

10 NAME OF FATHER John Abner Tabb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gloster Virginia

12 MAIDEN NAME OF MOTHER Rebecca Loyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Virginia

14 Informant Anne Lee Perrin

(Address) 813 Hamilton Terrace

15 Filed JAN 2 - 1925 ROBERT R. KRAUSER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1st 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15th, 1924, to Jan 1st, 1925, that I last saw her alive on Dec 31st, 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Senility Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? History & Symptoms

(Signed) Jos. Chatard, M. D.

(Address) 1300 a Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Point Virginia

DATE OF BURIAL Jan 2nd 1925

20 UNDERTAKER Henry Jenkins & Son Co

ADDRESS Colonial Inc Colloh St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Grubitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93569

CERTIFICATE OF DEATH.

D 93569

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 19 WARD)

2-FULL NAME Julia Grubitz

(a) RESIDENCE No. 345 S. Linwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Clothing Passer

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pottstown Penna.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital

15 Filed JAN 2 - 1925 RUSSELL R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21. 1924 to Dec 31. 1924

that I last saw h— alive on Dec. 31 1924

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

Cardiac Exhaustion.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pyelitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. J. Schmidt, M. D.

1/1/25 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan 3 1925

20 UNDERTAKER: Harry H. Weitzke — ADDRESS: 1531 W Lanvale

Spec.—1-10-21—M&T—1500 Bks.

93570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Paul ST., 4-1 WARD)

2-FULL NAME Charles M. Miller

(a) RESIDENCE NO. 117 Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Miller

6 DATE OF BIRTH (month, day, and year) March 2, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	53	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md.

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Bernhard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Frances Miller

(Address) 117 Paul St

15 Filed JAN 2 - 1925, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I attended deceased from November 5 1924 to January 1 1925, that I last saw him alive on January 1 1925, and that death occurred, on the date stated above, at 11.25 P.m.

The CAUSE OF DEATH* was as follows:

General Cardiac and respiratory exhaustion

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease, Aorta insufficiency (duration) 0 yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? prong

(Signed) John Lestapabury M. D.

19 Address 1037 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Jan 5 1924

20 UNDERTAKER Henry H Stritzke ADDRESS 1531 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93571

D 93571

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Camden Station St. No WARD)

2-FULL NAME Marcella Frazier

(a) RESIDENCE No 220 S. Bolden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15. 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	4	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant C. Frazier
(Address) 220 S Bolden St

15 Filed ..., 192 Robert P. Harrison, Registrar

JAN 2 - 1925 Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Farnell, M. D.
(Coroner.)

1-2, 192 5 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 4 1925
20 UNDERTAKER H. Sander Sons	ADDRESS 1310 West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93572

CERTIFICATE OF DEATH.

9-B 93572

1-PLACE OF DEATH

City of BALTIMORE: (No. Melrose & Roland Aves St., 27-15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Hume Satterthwaite

(a) Residence No. Melrose & Roland Aves St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 24/1924

7-AGE. ....yrs. 1 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS

10-NAME OF FATHER, Edward M Satterthwaite

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Moorestown N.J.

12-MAIDEN NAME OF MOTHER, J Hume Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Edward M Satterthwaite

(Address) Melrose & Roland Aves

15- Filed JAN 2 1925 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 1st - 25

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1924 to Jan 1st 1925

that I last saw h~~e~~ alive on Jan 1st 1925

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Incomplete Closure of Foramen Ovale

(Duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?....—

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Gunnell M. D.

Jan 1st, 1925 (Address) 4309 Fahnestock Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemetery	Jany 3, 1925
20-UNDERTAKER.	ADDRESS
Harry H Limmer	4204 Ridgewood Ave

21—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93573

CERTIFICATE OF DEATH.

101-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Light St. 23 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie F. Weller

(a) RESIDENCE. No. 1406 Light St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired, Sales lady

(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

(c) Name of employer: Hutzler Bros Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Waldschmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Carl Albach (Address) 2 E Randall St

15 Filed JAN 2 1925 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1924, to Dec 31 1924, that I last saw her alive on Dec 31 1924, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 1/4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Wm Lee Clopton, M. D.

12/31 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 3rd 1925
20 UNDERTAKER	ADDRESS 1084 Hanover St
D Scholomon & Son	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-601 D 93574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Barget

(a) RESIDENCE NO. ? 933 Harford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	? Married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? Baker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Not Known
(State or country)

PARENTS

10 NAME OF FATHER Joseph H Barget

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

JAN 2 - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-30, 1924, to 12-31, 1924

that I last saw him alive on 12-31, 1924

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ... yrs. ... mos ? ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude C. Dean, M. D.

1-1, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 2 1925
20 UNDERTAKER	ADDRESS
Henry Hoffmeister	1001 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93575

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. J. Conroy

(a) RESIDENCE NO. 501 E. Barney ST., WARD

(Usual place of abode) unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam-Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) 060

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington Del (State or country)

PARENTS

10 NAME OF FATHER James Conroy

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Gorman

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ..... Robert P. Harrison, Registrar

JAN 2 - 1925

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1924, to 12-31, 1924, that I last saw him alive on 12-30, 1924, and that death occurred, on the date stated above, at 3^00 a. m.

The CAUSE OF DEATH* was as follows:

Luetic aortitis, aortic insufficiency, aneurysm of ascending arch. Sarcoma of left tibia with extension to abdomen (duration) 1 yrs. 3 mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & X-ray

(Signed) Claude S. Lenhart, M. D.

12-31 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL Jan 3 1925

20 UNDERTAKER Lilly & Zeiler — ADDRESS 4038 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93576

1-PLACE OF DEATH

City of BALTIMORE: (No. 3005 O. Donnell St., 1-4 Ward) 10

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores Regena Friedel

(a) Residence No. 3005 O. Donnell St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 21st 1920

7-AGE. 4 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of Industry, business, or establishment in which employed (or employer). do

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS

10-NAME OF FATHER. John T. Friedel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Isabella Streelhaw

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant). John T. Friedel

(Address) 3005 O. Donnell St.

15- Filed JAN 2 1925 192 Robert F. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 1st 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 19 24 to Jan 1 19 25

that I last saw her alive on Jan 1 19 25

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Tonsillar Diphtheria

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) Horace B. Tatlow M. D.

1/2 19 (Address) 351 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 3. 1925
20-UNDERTAKER. Lilly & Geiser	ADDRESS 4033 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 21 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Ey.

(a) RESIDENCE NO. 1121 Sargeant St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Minnie C. Ey.

6 DATE OF BIRTH (month, day, and year) February 2, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine operator.
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Agustus Ey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Louisa.------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Minnie C. Ey. (wife)
(Address) 1121 Sargeant St.

15 Filed JAN 2 1925, 192 Robert P. Harris, Registrar

Burial P...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 31, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

Jany. 2nd. 1925 (Address) 1011 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL Jan. 3 1925

20 UNDERTAKER W.M. Cook.

ADDRESS 502 E. North Ave.

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93578

CERTIFICATE OF DEATH.

188-093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Robert Wood

(a) RESIDENCE No. 2127 N. Pulaski ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert N. Wood

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Curry

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Robert N. Wood.
(Address) 2127 Pulaski St.

15 Filed ..... 1925, 192 Robert P. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushing injury to chest (accidental) 5 minutes (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (automobile accident) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

1925 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Jany 3 1925
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1904 W. North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILM

Cor.—1-12-23—M&T—100 Bks.

D 93579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93579

CERTIFICATE OF DEATH.

X188-003

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. N Charles St., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm J Martin

(a) RESIDENCE No. Federal Harford Co. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Accountant
(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Martin

11 BIRTHPLACE OF FATHER (city or town) Howard Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Ann Morris

13 BIRTHPLACE OF MOTHER (city or town) Howard Co Md
(State or country)

14 Informant Jno C Lefurrier
(Address) Federal Harford Co Md

15 Filed JAN 2 1925, 192 Robert P. Harrison, Registrar
Burial Permit Cleark

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2. 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Automobile Accident

Inquest Pending

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison, M. D.
Coroner.

Jan 2, 1925 (Address) 5232 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Peters Cem DATE OF BURIAL Jan 5 1925

20 UNDERTAKER M Tuke Sons ADDRESS 827 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

S·A·F·E·T·Y

Spec.—1-10-21—M&T—1500 Bks.

Sv. 160 dray — 400 N. Payson

D 93580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93580

CERTIFICATE OF DEATH.

91-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 N Appleton ST., 16-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Virginia Davis

(a) RESIDENCE NO. 606 N. Appleton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home do

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Commerlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edw. A. Wrede

(Address) 627 N. Calhoun

15 Robert P. Harrison, Registrar

Burial Permit Clerk

N 2 - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1925

17 I HEREBY CERTIFY, that I attended deceased from Dec 1, 1924, to Jan 1, 1925

that I last saw him alive on Dec 31st, 1924

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. McCleary, M. D.

(Address) 700 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Lot.

DATE OF BURIAL 3 1925

20 UNDERTAKER Thomas Cook

ADDRESS 001 E Mon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY DAK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93581

D 93581

CERTIFICATE OF DEATH.

74-001

15-1

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3024 Garrison Ave ST., 15-1 WARD)

2-FULL NAME Annie M Turner

(a) RESIDENCE NO. 3024 Garrison Ave WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie M

6 DATE OF BIRTH (month, day, and year): Feb 3 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph McElfish

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Hardman 1/2

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Annie M Turner
(Address): 3024 Garrison Ave

15 NOV 2 - 1925 Robert P. Harrison, ... 19 ... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Apr-1923, 19..., to Jan-2- 19 25.

that I last saw h[illegible] alive on Jan-1- 19 25

and that death occurred, on the date stated above, at 1-30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

with Chronic Nephritis

(duration) ... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

(Address) 2202 Gorsuch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Jan 5 1925

DATE OF BURIAL

20 UNDERTAKER: Wm Cook & Son Est

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93582

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE No. South Balto. General Hospital ST. (If not in a hospital) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Oliver Kirk

(a) RESIDENCE. NO. 1500 Henry St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Lineman

(b) General nature of Industry, business, or establishment in which employed (or employer) Rail Road Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James H. Kirk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Debon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France

14 Informant Stanley O. Kirk
(Address) 1500 Henry St.

15 Filed ....., 19 .....

JAN 2 - 1925

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31st 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30th, 1924, to Dec. 31st, 1924, that I last saw him alive on Dec. 31st, 1924, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate

(duration) 38 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Dec. 30th 1924

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. H. Slogan, M. D.

, 19 (Address) 7 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetry	Jan. 3 1925
20 UNDERTAKER	ADDRESS
H. C. Brauning's Son	517 N. Schroeder St

I. B. WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93583

CERTIFICATE OF DEATH.

D 93583

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Webster ST. 24-70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Phillips

(a) RESIDENCE. No. 1405 Webster ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. S. Phillips

6 DATE OF BIRTH (month, day, and year) Feb. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cal Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs. Lillie Phillips 1405 Webster St

15 Filed JAN 3 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1924, to Dec 31, 1924, that I last saw her alive on Dec 31, 1924, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Stigell, M. D.

1/1, 1925 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Rd	1/3 1925
20 UNDERTAKER J. Kahney Howe	ADDRESS 1811 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state it. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-26—M&T—100 Blks.

D 93584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93584

CERTIFICATE OF DEATH.

1925

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10.)

2-FULL NAME Stanislaw Kurauk

(a) RESIDENCE NO. 607 S. Wolfe ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Stanislaw Kurauk

6 DATE OF BIRTH (month, day, and year) About 1882 Guess

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel
(c) Name of employer (Sparrows Point)

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown,

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Frances Kurauk (Address) 607 S. Wolfe St.

15 Filed JAN 3 1925 1925 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull accidental

(duration) yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Fell from scaffolding

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan. 1, 1925 (Address) 2512 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Jan 3, 1925
20 UNDERTAKER Fred W. Ozgurski	ADDRESS 1930 Eastern Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93585

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

City of BALTIMORE: (No. 535 N. Fulton Ave. St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Emma Smith.

(a) Residence No..... 535 N. Fulton Ave St., ... Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith.

6-DATE OF BIRTH (month, day and year) March-1-1848

7-AGE. 76 yrs. 10 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. John Singer.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany.

14- (Informant) Mrs. Emma Barnitt.

(Address) 535 N. Fulton Ave.

15- Filed ..... Robert P. Harrison, Registrar.

N 3 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31st 1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30th, 1924, to Dec. 31st, 1924, that I last saw her alive on Dec. 30th, 1924, and that death occurred, on the date stated above, at 10.30 A. m. The CAUSE OF DEATH* was as follows:

Old age

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John Vallas, M. D.

Jan 2, 1925 (Address) 5[illegible] Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park. DATE OF BURIAL. Jan. 3rd 1925.

20-UNDERTAKER. Charles J. Schwab. ADDRESS 505 N. Monroe St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3121 Abell ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine R Donnelly

(a) RESIDENCE NO. 3121 Abell ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-23-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Ireland Co Tyrone

PARENTS

10 NAME OF FATHER: Hugh McElroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Joseph Seufert

(Address) 3121 Abell ave

FILED JAN 3 - 1925

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 31, 1924, that I last saw her alive on Dec 30, 1924 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F J Powers, M. D.

1/1, 1925 (Address) 1921 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 3 1925
20 UNDERTAKER	ADDRESS
John F Fahy & Sons	1318 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE at last birthday. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93587

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 N Pratt ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominick P. Sanahan

(a) RESIDENCE. NO. 1138 N Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, ~~or Divorced (write the word)~~
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Winifred Lavan

6 DATE OF BIRTH (month, day, and year) Dec 31-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Sanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Lavan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine Sanahan

(Address) 1138 N Pratt

Filed JAN 3 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 26 1924 to Dec 31 1924

that I last saw him alive on Dec 30 1924

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Mutual Stamper & Reporter

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hattie E Trueman M. D.

(Address) 2002 N Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	Jan 3 1925
20 UNDERTAKER	ADDRESS
John J Feldo	1202 N Gilmor

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93588

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Montebello Terrace ST., 27-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Cullum

(a) RESIDENCE NO. 104 Montebello Ter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of George W. Cullum

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David Russell Whiteley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md

12 MAIDEN NAME OF MOTHER Sarah Anne McCauley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Anne R. Stevens

(Address) 104 Montebello Ter.

15 Filed ....., 19..... Robert P. Harrison, Registrar

JAN 3 - 1925

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 1. 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1924 to Jany 1. 1925, that I last saw h[illegible] alive on Dec. 31. 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

Jany 1. 1925 (Address) 2211 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Jan 8 1925

20 UNDERTAKER John B. Spence ADDRESS 1325 N. Caroline St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

D 93589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93589

CERTIFICATE OF DEATH.

10 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 809 N. Eden St., Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Smallwood

(a) Residence No. 809 N. Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of the late Alexander Smallwood

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE Years 46 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER Samuel Bowers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Alice Fenger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14- (Informant) Mrs Carrie Shaney Burk

(Address) Brooklandville Md

15- Filed DEC 31 1925 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1924 to Dec 30 1924

that I last saw h.. alive on Dec 30 1924

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Robt P. Green, M. D

12-31-, 1924 (Address) 123 Augusta St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	June 3, 1925
20-UNDERTAKER.	ADDRESS
Henry Horde Son	501 E Eager St

JUN 3 1925

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Cole

(a) RESIDENCE No. 2428 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Naomi B. Cole

6 DATE OF BIRTH (month, day, and year) Oct. 24 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas. H. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Naomi B. Cole

(Address) 2428 E Biddle St

15 Filed JAN 3 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1924, to Dec 31, 1924, that I last saw him alive on Dec 31, 1924, and that death occurred, on the date stated above, at 8:15 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/29/24

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) Isidor S. Frey, M.D.

Jan. 1925 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 3 1925
20 UNDERTAKER Henry Storch Son	ADDRESS 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93591

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 902 Light St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Gruss

(a) Residence No. 902 Light St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Sin

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 2-1910

7-AGE. 14 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER. George Gruss

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ohio

12-MAIDEN NAME OF MOTHER. Mary Mc Nancy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

11-(Informant) Mary Gruss.

(Address) 902 Light St

15-Filed JAN 3 - 1925 Robert P. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1924 to Dec 31 1924

that I last saw him alive on Dec 31 1924

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. E. Smith M. D.

(Address) 910 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Calvary Cem	Jan 3 1925
20-UNDERTAKER.	ADDRESS
Jacob A. Frantz & Son	703 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93592

D 93592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green Sts Balto WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest O Preston

(a) RESIDENCE NO. 5002 Brudek Ave ST. Forest Pk. WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Amelia V. Preston

6 DATE OF BIRTH (month, day, and year) Aug 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	4	27	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Jonas Preston

11 BIRTHPLACE OF FATHER (city or town) Conowingo
(State or country) Md

12 MAIDEN NAME OF MOTHER Mariah Ann

13 BIRTHPLACE OF MOTHER (city or town) Massachusetts
(State or country)

14 Informant Hospital Records
(Address)

15 Filed JAN 3 1925, 19 ..... Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1924, to Dec. 31, 1924, that I last saw him alive on Dec. 31, 1924, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Dec. 31-1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical appearance

(Signed) Anthony V. Bucheres M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Jan 3 1925

20 UNDERTAKER Wm J Tickner Sons — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.93593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.93593

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. Eye, Ear & Throat Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Base

(a) RESIDENCE. NO. Charles St. Bellona Avenue ST. Balto. Co. Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Name

6 DATE OF BIRTH (month, day, and year) July 24 - 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aikensville, Md.

PARENTS

10 NAME OF FATHER Wm. Daniel Base

11 BIRTHPLACE OF FATHER (city or town) (State or country) Emerson, Balto., Md.

12 MAIDEN NAME OF MOTHER Florence Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County Md.

14 Informant Wm. Base

(Address) Charles Bellona Ave Govans

Filed JAN 3 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1924, to Jan. 2, 1925, that I last saw her alive on Jan. 1, 1925, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? (Towson) Chas St Bellona

Did an operation precede death? yes Date of Dec. 19/24 12/24/24

Was there an autopsy? no.

What test confirmed diagnosis? Blood culture

(Signed) Jat Pfeiffer M. D.

. 19 (Address) Balto. Eye Ear & Throat Hospital (1934 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem.	Jan 4 1925
20 UNDERTAKER	**ADDRESS**
John Burns Sons	Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 S. Robinson ST. 1-3 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gorniak

(a) RESIDENCE No. 1001 S. Robinson ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. - mos. - ds. How long in U. S., if of foreign birth? 40 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Casper Kozlok

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zofia Gawzych

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jacob Gorniak

(Address) 1001 S. Robinson St

15 [illegible] Robert P. Harrison, Registrar

JAN 3 - 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Dec 31, 1924, that I last saw her alive on Dec 31, 1924, and that death occurred, on the date stated above, at 11-20 p m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 4 hrs ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J Davidson, M. D.

, 19 (Address) 2028 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 5 1925
20 UNDERTAKER	ADDRESS
Stephen L Fialkowski	1002 Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of SUBDIVISION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93595 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93595

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Luzerne Ave. ST., 6-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Matilda Robier

(a) RESIDENCE NO. 214 N. Luzerne Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas M. Robier

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Parrott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Florence Robier

(Address) 214 N. Luzerne Ave.

15 Filed JAN 3 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1924, to Dec 31, 1924, that I last saw her alive on Dec 31, 1924, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

General Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. Fleming, M. D.

Jan 3 1925 (Address) 1707 Lexington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Jan. 3, 1925

20 UNDERTAKER: Wm. C. Black, ADDRESS: 927 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

D 93596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93596

CERTIFICATE OF DEATH.

128

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 N. Rose ST., 7-3 WARD)

2-FULL NAME Matilda Ruby

(a) RESIDENCE NO. 510 N. Rose ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Edward Ruby

6 DATE OF BIRTH (month, day, and year) May 9-1886

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Bond.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edward Ruby (Address) 510 N. Rose St

15 Filed ..... 19 Robert P. Harrison, Registrar

~~1925~~ Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 31 1924

17

I HEREBY CERTIFY, That I attended deceased from ..... 19 24 to Dec 31 19 24

that I last saw h[illegible] alive on Dec 31 19 24

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Acute diffuse Nephritis (cause unknown) marked Dyspnea

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) E. L. Edwards M. D.

(Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Jan 3 1925

20 UNDERTAKER Geo E. Miller & Son ADDRESS 2337 Jeffer[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See Instructions on back of certificates.

N 3

Spec.—1-10-21—M&T—1500 Blks. (Neumann)

D 93597 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93597

CERTIFICATE OF DEATH.

REGISTERED NO. 1-3 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 1-3 WARD)

2-FULL NAME Christian Neuman

(a) RESIDENCE No. 808 S Conkling ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Neuman

6 DATE OF BIRTH (month, day, and year) Dec 21 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can Maker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Neuman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mary Neuman (Address) 808 S Conkling

15 Filed JAN 3 1925, 19 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2-1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1924 to Jan 2, 1925

that I last saw he alive on Jan 2, 1925

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Embolus

(duration) instantly yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Pyloric End of stomach (duration) 1 yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/30/24.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) K. W. Golley, M. D.

. 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehnerts Cemetery

DATE OF BURIAL Jan 6 1925

20 UNDERTAKER John Ullrich

ADDRESS Govt Orleans

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE at last birthday and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93598

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 853 Park ave ST. 11-2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. James J. Mills

(a) RESIDENCE No. 853 Park Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary H. Hill

6 DATE OF BIRTH (month, day, and year): Dec 16. 1863

7 AGE: Years 62 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: James Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Maria Milner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mary H. Hill

(Address) 853 Park ave

15 Filed ..... Robert P. Harrison, Registrar

JAN 3 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Janu 2 1925

17

I HEREBY CERTIFY, That I attended deceased from July ... 1923 ... to Janu 2 ... 1925.

that I last saw h is alive on Janu 1st ... 1925.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) immediate cause yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema - Chronic bronchitis (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?.. Date of .....

Was there an autopsy? .....

What test confirmed diagnosis?

(Signed) Thos. R Boggs M. D.

, 19 (Address) 1013 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Janu 5 1925

20 UNDERTAKER: John O. Mitchell

ADDRESS: 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Weir) Time of burial selected by Jan 6 1925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93599

1645 D 93599

CERTIFICATE OF DEATH.

J. Frederick Stumpf Asst. Comr

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO. 122

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

2-FULL NAME Bertha M Weir

(a) RESIDENCE NO. 3402 Hunter ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Weir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sophie Gorecka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czechoslovakia

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 JAN 3 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 - 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1924, to Jan 1 -, 1925, that I last saw her alive on Jan 1, 1925, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Poliomyelitis; Secondary

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Jan 4 1925

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/93600

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 610 Stockton ST., 16-7 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Corbin

(a) RESIDENCE NO. 610 Stockton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 11 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Mary Corbin

6 DATE OF BIRTH (month, day, and year) Jan 11-01

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	23	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Corbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Alice Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Corbin

(Address) 610 Stockton St

15 Filed JAN 3 - 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 192X, to Jan 1, 1925, that I last saw him alive on Dec 31, 192X, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. Williams Fiery, M. D.

Jan 1, 1925 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Jan 3 1925

20 UNDERTAKER Sam'l W. Chaselow ADDRESS 1400 Mosher

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] CUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93601

CERTIFICATE OF DEATH.

101-00
15 - 13

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1308 Stricker ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Queen

(a) RESIDENCE NO. 308 Stricker ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Queen

6 DATE OF BIRTH (month, day, and year) Oct 10- 75

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nathaniel Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Queen
(Address) 308 N Calhoun

15 Filed JAN 3 1925, 19 Robert P. Harriss, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924, to Jan 1, 1925, that I last saw h[illegible] alive on Jan 1, 1925, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

Jan 3, 1925 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Jan 4 19 25
20 UNDERTAKER	ADDRESS
H T Grace & Son	1405 Mad[illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93602 D 93602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1403 N. Carolina St. St., 8-3 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bachman

(a) Residence No. 1403 N. Carolina St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Late Elizabeth Bachman

6-DATE OF BIRTH (month, day and year) 1854

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Later.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS:

10-NAME OF FATHER, John Bachman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Von Bruen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Mrs. D. Bachman

(Address) 1403 N. Carolina St.

15- Filed 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1st 1925

17- I HEREBY CERTIFY, That I attended deceased from March 1st 1925 to June 1st 1925

that I last saw him alive on Dec 31st 1924

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Entire Insusficiency

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analysis

(Signed) L. McCarthy M. D.

June 3 1925 (Address) 1114 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore County. DATE OF BURIAL, 1 3 1925

20-UNDERTAKER. Geo. J. Ruth. ADDRESS 1735 Harford Ave

N 3

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Albert

D 93603

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

D 93603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital 28-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr A. J. Alford (Albert)

(a) RESIDENCE NO. 3806 Gwynn Oak Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Clara A Alford

6 DATE OF BIRTH (month, day, and year) Dec. 9- 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sporting

(b) General nature of industry, business, or establishment in which employed (or employer) good Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER Amore Alford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Erina G. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Mrs Clara A Alford

(Address) 3806 Gwynn Oak Ave

Filed JAN 3 1925, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to Jan 2, 1925, that I last saw him alive on Jan 2, 1925, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia -

Chronic Nephritis

Broncho Pneumonia - duration - 4 days

Ch Nephritis (duration) 18 yrs. mos ds.

CONTRIBUTORY (Secondary) senile Cardiac Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical - & autopsy.

(Signed) Clement R. Monat, M. D.

, 19 (Address) West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Jan 5 1925
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins St

FB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 16-490

City of BALTIMORE: (No. 916 N. Monroe St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Theresa M. Wolff

(a) Residence No... 916 N. Monroe St., Ward...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank A Wolff

6-DATE OF BIRTH (month, day and year) Sept 24, 1842

7-AGE, 82 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Hanover (State or Country), Germany

PARENTS.

10-NAME OF FATHER, F. Wilhelm Haupt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Heinmeyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-
(Informant) Gertrude Wolff
(Address) 916 N. Monroe St

15-
Filed JAN 2 - 1925
Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 2, 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1924, to Jan. 2, 1925, that I last saw her alive on Jan. 1, 1925, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Old age

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no, Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Herbert S. Blake M. D.

, 19 (Address) 1014 W. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Jan. 5, 1925

20-UNDERTAKER, George J Smith — ADDRESS 1532 Hollins St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 25-7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Geoghgan

(a) RESIDENCE NO. 521 Patapsco Ave. ST., Brooklyn WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year): Jan 2nd 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER James Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Margaret Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Bay View Hospital Baltimore, Md.

15 Filed JAN 3 - 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/31/ 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1924 to Dec 30, 1924, that I last saw h[illegible] alive on Dec 30, 1924 and that death occurred, on the date stated above, at 4.25 P m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Obesity & Advanced Cerebral Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. [illegible] M. D.

1/3/ 1925 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 1/3/ 1925

20 UNDERTAKER: E. J. Fanning (Inc) — ADDRESS: 1460 Battery Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should file CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

93606

HEALTH DEPARTMENT—CITY OF BALTIMORE

93606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 308 Worseley St., 12-590 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maggie Matthews

(a) Residence No. 308 Worseley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Matthews

6-DATE OF BIRTH (month, day and year) 1879

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic - 010

(b) General nature of industry, business, or establishment in which employed (or employer). Personal Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Texas

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Lewis Jackson

(Address) 308 Worseley St

15- Filed JAN 3 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 31. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1924 to Dec 30 1924

that I last saw h[illegible] alive on Dec 30, 1924

and that death occurred, on the date stated above, at 1:30P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.M. Physical Ex —

(Signed) [illegible] M. D.

Jan 1, 1925 (Address) 1534-O St. N.W.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery — DATE OF BURIAL. Jan 3, 1925

20-UNDERTAKER. Mrs Jas. H. Dennis — ADDRESS 1303 Presstman St

per T. E. Nelson.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1-1 WARD) 161-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Grimage

(a) RESIDENCE NO. Chase, Balto. County ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1924

7 AGE — Years — Months — Days: one — If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Grimage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosie Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant

(Address) Johns Hopkins Hospital

15 Filed JAN 3 - 1925, 19 Robert P. Harrison, Registrar

0003

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1924, to Dec. 24, 1924, that I last saw h~~im~~alive on Dec. 24, 1924, and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Extra-cranial (cerebral) hemorrhage

one

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E L Stone, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health, — ADDRESS JAN 2 - 192

Dep. Wm. E. Woodall

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

406

Spec.—1-10-21—M&T—1500 Bks.

D 93608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S. High st ST., 3-1 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Sofia

(a) RESIDENCE NO. 205 S. High st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX fem.

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Giovanni Sofia

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Carmela Spitto

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant

(Address)

15 Filed 1925, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 31/, 1924, to Jan 2nd, 1925, that I last saw her alive on Jan 1st, 1925, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

prematurity (7 months)

(twin)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Testa M. D.

1925 (Address) 710 Park st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Bureau of Vital Statistics

ADDRESS JAN 2 1925

Per. Wm. H. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

405

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93609

D 93609

CERTIFICATE OF DEATH.

161-0010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S. High st ST., 3-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Sofia

(a) RESIDENCE No. 205 S. High st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31st 24

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Batto ma (State or country)

PARENTS

10 NAME OF FATHER Giovanni Sofia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmela Pirillo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1925, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1st 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 1, 1925, that I last saw him alive on: Dec 31, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (seven months)

(Twin)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Testa, M. D.

1/2, 1925 (Address) 210 Pearl st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL JAN 2 - 1925 19

20 UNDERTAKER Commissioner Health ADDRESS

WHITE PRINT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 93610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93610

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1701 Bolton St. ST. (WARD) 142

2-FULL NAME Rapold Sternsdorf

(a) RESIDENCE. No. 1701 Bolton St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bally

PARENTS

10 NAME OF FATHER Abraham Sternsdorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant David Sternsdorf
(Address) 1701 Bolton St

15 FILED JAN 3 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1924, to Dec 31, 1924.

that I last saw him alive on Dec 31, 1924.

and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leck, M. D.

1-1, 1925 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai	1/4 1925
20 UNDERTAKER	ADDRESS
John J. Fahey & Son	1818 E. Lafayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93611

D 93611

CERTIFICATE OF DEATH. + 57

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Md General Hosp ST., 11-W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Winfield E Price

(a) RESIDENCE NO. Newark Del ST., WARD Newark Del.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Merrill Pence

6 DATE OF BIRTH (month, day, and year) 1-20-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	33	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Grantham Co Md

PARENTS

10 NAME OF FATHER J. A. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Sumpter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Winfield Price (Address) Newark Del

15 Filed , 19 Roberts P. Hartman, Burial Permit Clerk Registrar

JAN 3 - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7-25 19

17

I HEREBY CERTIFY, That I attended deceased from 10-16-24 to 1-2-25, 19, that I last saw her alive on 1-7-25, 19, and that death occurred, on the date stated above, at 7 05 p m.

The CAUSE OF DEATH* was as follows: 1

Diabetic Myelitis

Ch. Myocarditis

Ac. Dilatation

Arter. Clerosis (duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Lewis, M. D.

(Address) Md Grantham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Converse Miami Dale Co Fla DATE OF BURIAL Jan 3rd 19 25

20 UNDERTAKER Putnam & Lose ADDRESS 1723 N Charles Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93612

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital 118

City of BALTIMORE: (No. Bay View Asylum 26-7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Clavell

(a) Residence No. Colgate Maryland Ward

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred Jmos 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER George Clavell

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Caroline Thompson

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Maryland

14- (Informant) Hospital Records

(Address) Bay View Hospital

15- Filed JAN 3 - 1925 By Robert P. Harrison, Registrar.

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 1 1925

17- I HEREBY CERTIFY, That I attended deceased from May 23 1924 to Jan 1, 1925.

that I last saw h alive on Jan 1 1925

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Indirect Inguinal Hernia -

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inguinal Bowels

Pneumonia (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 29-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab Tests

(Signed) Dr. P. Chandler M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1925
Mt Carmel	Jan 3
20-UNDERTAKER. Zirkle & Zirkle	ADDRESS 1739 Eager

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hosp 9-W 129 Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Brown

(a) Residence No. 1730 N. Caroline St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara B. Brown

6-DATE OF BIRTH (month, day and year) Sept. 3, 1871

7-AGE. 53 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Pa. R. R. Co.

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER, George Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Mary Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Clara B. Brown

(Address) 1730 N. Caroline

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

JAN 2 - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 2, 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1924 to Jan 2, 1925

that I last saw h. alive on Jan 2, 1925

and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Fatty Heart mtl
Annular Fibrillation
(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Chron.)
(Duration) 1 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. B. Sylvest M. D

1/2, 1925 (Address) St. Jos. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Jan 5, 1925
20-UNDERTAKER. Funkhouser Funkhouser	ADDRESS 1734 Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93614

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 830 N. Luzerne St., 7-2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Menzel

(a) Residence No. 830 N. Luzerne St., Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Peter C. Menzel

6-DATE OF BIRTH (month, day and year) Jan. 3, 1857

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Germany

PARENTS.

10-NAME OF FATHER Nicholas Riebel

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) Joseph Menzel

(Address) 830 N. Luzerne

15- Filed 1925 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3, 1925

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h... alive on ..... 19.....

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

. 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL. Jan 6, 1925

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1738 Eager st

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 3

SEE TYPE S-A-F

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93615

HEALTH DEPARTMENT--CITY OF BALTIMORE

701-001

D 93615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Noel

(a) Residence No. (Usual place of abode) Monastery Road, Waverhope St. Md. Ward.....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word): married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Emma Noel

6-DATE OF BIRTH (month, day and year): Aug 5th 1888

7-AGE: 36 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Builder

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Bayside County Md.

PARENTS:

10-NAME OF FATHER: Sandford Noel.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Carroll County Md.

12-MAIDEN NAME OF MOTHER: Minnie M. Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Edmond County Md.

14-Informant: Mrs. Emma Noel

Address: Monastery Road Waverhope

15-Filed JAN 3 - 1925, 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 31/24

17- I HEREBY CERTIFY, That I attended deceased from December 30 1924 to December 31. 1924

that I last saw h[illegible] alive on Dec. 31st 1924

and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Emphysema Chronic

(Duration) yrs. 1 mos. ds

CONTRIBUTORY (Secondary): Septicaemia

(Duration) yrs. mos. 14 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/3/24

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) Samuel A. Clayton M. D

19 (Address) 3 E. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 1925

UNDERTAKER: J. B. Stuppert

ADDRESS: 1850 N. Balto St

THIS CERTIFICATE, WITH UNDERLINED ITEMS, IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 93616 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93616

CERTIFICATE OF DEATH.

154-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 1700 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Heggins

(a) RESIDENCE NO. 330 Whitridge Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Reuben Heggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England, do not know

12 MAIDEN NAME OF MOTHER Ethel E. Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " Md.

14 Informant Reuben Heggins

(Address) 330 Whitridge Ave.

15 Filed JAN 3 - 1925, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 30th, 1924, to Jan. 2nd, 1925, that I last saw him alive on Jan. 1st, 1925, and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Newman R. Trudeau, M. D.

, 19 (Address) St Agnes Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Jan 3 1925

20 UNDERTAKER Harry L. Weitzle

ADDRESS 153 Monument

Burial Permit Clerk

N.B.—WHERE PLAIN, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of name is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93617

CERTIFICATE OF DEATH.

7/4-001

D 93617

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Whitelock St., 13-6 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Rose Libowitz

(a) Residence No. 909 Whitelock St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan

6-DATE OF BIRTH (month, day and year) 1865

7-AGE, 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Solomon Sirkis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Nathan Libowitz

(Address) 909 Whitelock St

15- Filed JAN 4 - 1925 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3/25

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1924, to Jan 3, 1925, that I last saw h[illegible] alive on Jan 3, 1925, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Apoplexy)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms etc

(Signed) Benjamin Adelman, M. D.

Jan 3, 1925 (Address) 1804 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Herrlich Herring Pk

DATE OF BURIAL, Jan 4, 1925

20-UNDERTAKER. Sol Simson & Bro

ADDRESS 1127 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93618

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH U.S. Marine Hospital No 1 Baltimore, Md

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Somera

(a) RESIDENCE NO. U.S Marine Hospital # 1 Baltimore Md ST., ... WARD —
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaca

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self
(Address)

15 Filed JAN 4 - 1925, 19 .... RUBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1924, to January 2, 1925, that I last saw him alive on January 2, 1925, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows: Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination Laboratory findings

(Signed) A. F. Ales, M. D.

1/V, 1925 (Address) U.S. Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetry — DATE OF BURIAL Jan 4 1925

20 UNDERTAKER Sol Simmons & Bro — ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 93619

CERTIFICATE OF DEATH.

47

D 93619

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 111 Aisquith St., 5-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham A. Vinnick

(a) Residence No. 111 Aisquith St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? 27 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline

6-DATE OF BIRTH (month, day and year) 1842

7-AGE, 83 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Julius Vinnick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-Informant, Hyman Vinnick

Address, 1317 N Gay st

15-Filed JAN 4 - 1925 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3/25

17- I HEREBY CERTIFY, That I attended deceased from Aug, 1924, to Jan 3 '25, 1925, that I last saw h.. alive on Jan 2 '25, 1925, and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Levinson, M. D.

1-3, 1925 (Address) 30 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Hering Fun — DATE OF BURIAL, Jan 4, 1925

20-UNDERTAKER, Sol Levinson & Bro — ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93620

CERTIFICATE OF DEATH. 159-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4021 Reisterstown Rd Ward 15-3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Norman Shpritz

(a) Residence No. 4021 Reisterstown Rd Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? 4 yrs. 10 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Sngle

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 12 20

7-AGE. 4 yrs. 10 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Benj Shpritz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Dina Pearlman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Benj Shpritz

(Address) 4021 Reisterstown Rd

15-

Filed....., 19..

Registrar.

JAN 4 - 1925 ROBERT F. KRAUSER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3-25

17- I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924 to Jan 3, 1925

that I last saw h.. alive on Jan 3, 1925

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Congenital)

Life (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

Jan 3, 1925 (Address) 2687 Wrestens Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Pikesville Rosedale — DATE OF BURIAL. Jan 3, 1925

20-UNDERTAKER. Sol Levinson & Bro — ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bka.

D 93621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93621

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Moreland Ave ST., 15-11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matley Mourer

(a) RESIDENCE No. 1608 Moreland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Mourer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	68	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Harry Mourer
(Address) 1608 Moreland Ave

15 Filed JAN 4 - 1925, 19.. ROBERT P. KRAMER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 2, 1925 (Address) 2702 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bald Hebzon Cem — DATE OF BURIAL 1/4 1925

20 UNDERTAKER Jack Lewis 1439 E Baltimore — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93622

CERTIFICATE OF DEATH.

188-003 D 93622

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14-1 WARD)

2-FULL NAME Richard Iff

(a) RESIDENCE NO 204 Penna Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1- 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Treated Stuck a Lathe

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) From From Acc

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Grauel M. D.
(Coroner.)

1-3, 1925 (Address) 117 N Gaulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herrun Run

DATE OF BURIAL 1/4 1925

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93623 ✓ D 93623

CERTIFICATE OF DEATH.

197

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 7-1 WARD)

2-FULL NAME Samuel Greser

(a) RESIDENCE NO 1712 E. Madison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gussie Greser

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Greser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose -------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) E. Balto St

15 JAN 4 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-pistol shot through both lungs- Probable homicide

(Inquest to be held Jan 5/25)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Jos H Kolen (Coroner.) M. D.

Jan 3/25 192 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrem Rosedale	1/4 192 5
20 UNDERTAKER Joh Lewis 1439	ADDRESS E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93624

CERTIFICATE OF DEATH.

129 D 93624

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Ashland ave. ST.; 7-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kaplan

(a) RESIDENCE. No. 1635 Ashland ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 / yrs. mos. ds. How long in U. S., if of foreign birth? 3 / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Kaplan

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS
10 NAME OF FATHER: Abraham Orlovsky
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: Rose
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Sam. Kaplan
(Address) 2531 Ashley ave

15 DATE RECEIVED: JAN 4 - 1925
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1924, to Jan. 2, 1925.
that I last saw her alive on Jan. 2, 1925.
and that death occurred, on the date stated above, at 9.45 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 20 yrs. — mos. — ds.
CONTRIBUTORY (Secondary): Uremia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab. & Clinical Findings

(Signed) John A. Buchness, M. D.
1/7, 1925 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balt Hebrew Cem | DATE OF BURIAL: 1/4 1925

20 UNDERTAKER: Jack Levis | ADDRESS: 1489 E Balt

INFORMATION REQUIRED, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 lks.

D 93625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 93625

1-PLACE OF DEATH

City of BALTIMORE: (No. 5107 Grove Ave St., 27-9 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Meisenhalder

(a) Residence No. 5107 Grove Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Meisenhalder

6-DATE OF BIRTH (month, day and year) March 13, 1841

7-AGE. 84 yrs. 9 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Schroeder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) Henry Doulong

(Address) 5707 Grove Ave

15- Filed JAN 4 1925 Joseph E. Kramer Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 1 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1924 to Jan 1 1925.

That I last saw h[illegible]ative on " " 1925.

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Duncan, M. D.

Jan 2, 1925 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Matthews Cemetery

DATE OF BURIAL. Jan 4 1925

20-UNDERTAKER. L. Sander Sons

ADDRESS 1710 Fleet St

SHADED SPACES—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93626

CERTIFICATE OF DEATH.

101-001

D 93626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 656 Pitcher ST., 14-1 WARD)

2-FULL NAME Minnie Williams

(a) RESIDENCE NO. 656 Pitcher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Williams

6 DATE OF BIRTH (month, day, and year) Aug 18, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Josiah Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Pa.

12 MAIDEN NAME OF MOTHER Alice Bussoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Pa.

14 Informant Alice Ellen (Address) Windsor Mill R/D

15 Filed ..... 19 ..... ELLA R. KRAUTER, Registrar

JAN 4 1925

0014 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924, to Jan 1, 1925.

that I last saw h[illegible] alive on Dec 30, 1924.

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. William Frey M. D.

1/6, 1925 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Jan 5 1925

20 UNDERTAKER [illegible] ADDRESS [illegible]

[illegible] Wm. E. Williams

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

H O

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93627

CERTIFICATE OF DEATH.

38 D 93627

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 E. Monument ST., 71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hazel

(a) RESIDENCE No 1528 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hazel

6 DATE OF BIRTH (month, day, and year) Nov 25/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Stevedore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Hazel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. Hazel
(Address) 1525 Orleans St

15 Filed JAN 4 - 1925, 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage-Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Luetic (duration) yrs. mos. ds.

(Signed) J S H Fuller, M. D. (Coroner)

Jan 3/25 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Jan DATE OF BURIAL 4 192 5

20 UNDERTAKER Milton Davis ADDRESS 315 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 93628

CERTIFICATE OF DEATH. + 10 D 93628

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST.: 9-2 WARD)

2-FULL NAME Carolina Deppisch

(a) RESIDENCE. No. Old Hanford Rd-Parkville ST.. WARD.
(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Deppisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Marg. Wehner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Frank Deppisch
(Address) Old Hanford Road Parkville

15 Filed ..... 19..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 2, 1925, that I last saw h alive on Jan 2, 1925 and that death occurred, on the date stated above, at 8 10 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pos. Klebs Culture

(Signed) Myron G. Tull, M. D.

Jan 3 1925 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 4 1925

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 93629

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 Cold Spg Lane St., 27-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Edward M. Heath

(a) Residence No. 903 Cold Spg Lane St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Laura R. Heath

6-DATE OF BIRTH (month, day and year) Jan 25 1872

7-AGE, 52 yrs. 11 mos. 7 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9-BIRTHPLACE (city or town) (State or Country). Balto Co Md

PARENTS.

10-NAME OF FATHER Linton Heath

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Annie Shawbacker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mr Laura R. Heath

(Address) 903 Cold Spg Lane

15- Filed ... 192 ... Registrar.

JAN 4 - 1925 RUSSEL R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 2 25

17- I HEREBY CERTIFY, That I attended deceased from Nov 27, 1925 to Jan 2, 1925

that I last saw h[illegible] alive on Jan 2, 1925

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Arteriosclerosis (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? no

What test confirmed diagnosis? urine

(Signed) Harry C. Pegues, M. D.

Jan 3, 1925 (Address) 3640 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. David Ridge | DATE OF BURIAL, Jan 5 1925

20-UNDERTAKER, R S Marshall | ADDRESS 3539 Falls Rd

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 93630

CERTIFICATE OF DEATH.

101-001 D 93630

1-PLACE OF DEATH

City of BALTIMORE: (No. 728. N. Kenwood ave Ward) 9 ×3

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Gilda Colaiamni

(a) Residence No. 728. N. Kenwood ave Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2/7-1907

7-AGE. 16 yrs. 10 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balt Md.
(State or Country).....

PARENTS.

10-NAME OF FATHER, Joseph Colaiamni

11-BIRTHPLACE OF FATHER (city or town) Italy
(State or Country).....

12-MAIDEN NAME OF MOTHER, Maria Fontanazza

13-BIRTHPLACE OF MOTHER (city or town) Italy
(State or Country).....

14- (Informant) Joseph Colaiamni

(Address) 728. N. Kenwood ave

15- Filed JAN 4 - 1925 192.. ROBERT R. KRAMER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 1924 to Dec. 31 1924

that I last saw her alive on Dec. 31 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Con P Schmidt M. D

Jan 3 1925 (Address) 701 N Kenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL, Jan. 4 1925

20-UNDERTAKER, George F. Ruth ADDRESS 1735 Harford ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93631

CERTIFICATE OF DEATH.

31

D 93631

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 10 N. Paca st St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Krautzun

(a) Residence No. 10 N. Paca st St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Krautzun.

6-DATE OF BIRTH (month, day and year) April 28 1889

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Engelbach.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary E Sheehan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Bernard Krautzun

(Address) 10 N. Paca st.

15- JAN 4 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 1 1926

17- I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924 to January 1, 1926 that I last saw her alive on January 1st 1926 and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Pharyngeal Tbc

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Sputum Exam.

(Signed) Louis F. Krumiem M. D.

, 19 (Address) 722 North Kenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	Jan. 5, 1925

20-UNDERTAKER. ADDRESS

George J. Ruth 1735 Harford ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93632

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 524 Orchard ST., 17 W (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella N. Boardley

(a) RESIDENCE NO. 524 Orchard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia F Boardley

6 DATE OF BIRTH (month, day, and year) Nov 2-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Foot R.I.

PARENTS

10 NAME OF FATHER John A Boardley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Foot R.I.

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anderson

14 Informant Amelia F Boardley

(Address) 524 Orchard St

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1924 to Dec. 29, 1924

that I last saw him alive on Dec. 29, 1924

and that death occurred, on the date stated above, at 1-15 P m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

for at least (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

for probably (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eldridge C. Price M. D.

19 (Address) 1705 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	1/4 1925
20 UNDERTAKER Samuel T Grimsley	ADDRESS 578 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Bks.

D 93633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-1 31 ✓ D 93633

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (ST.) (WARD)

2-FULL NAME James Jackson

(a) RESIDENCE NO. 1545 Fremont ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not given

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Simon Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Georgiana ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed JAN 4 - 1925 JOSEPH A. KRAUSER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 1, 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1924, to Jan. 1, 1925,

that I last saw him alive on Jan. 1, 1925,

and that death occurred, on the date stated above, at 6.05 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Laboratory

(Signed) J. D. Lokie, M. D.

1-2-, 1925 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 1/5 1925

20 UNDERTAKER: Samuel H. Kennedy — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 93634

REGISTERED NO.

1-PLACE OF DEATH Municipal T.B. Hospital

CITY OF BALTIMORE: (NO. Bay View ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Jones.

(a) RESIDENCE NO. 234 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Jones.

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer) 0110

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records Address 34 W Preston St

15 Filed JAN 4 - 1925 [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21st, 1924, to Jan 1st, 1925, that I last saw him alive on Jan 1st, 1925, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) [illegible] mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clin. & Lab. findings

(Signed) L. T. White. M. D.

1, 1925 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cockeysville Md

DATE OF BURIAL 1/4 1925

20 UNDERTAKER Samuel D Kennedy

ADDRESS 678 N Bedale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93635

CERTIFICATE OF DEATH.

129 D 93635

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Mc Culloh ST., 14-1 WARD)

2-FULL NAME Violet D. Brown

(a) RESIDENCE NO. 2117 Mc Culloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Brown

6 DATE OF BIRTH (month, day, and year) Dec. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (City or town) Pikeville - Md.
(State or country)

PARENTS

10 NAME OF FATHER Elijah Bowman

11 BIRTHPLACE OF FATHER (City or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bowman

13 BIRTHPLACE OF MOTHER (City or town) Md.
(State or country)

14 Informant John Brown (Address) 2117 Mc Culloh St

15 Filed JAN 4 - 1925, 19 ROGER T. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1924 to Dec. 31, 1924 that I last saw her alive on Dec. 31, 1924 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo-Nephritis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ex. of Urine & Blood.

(Signed) W. V. Carr, Jr., M. D.

Jan. 3, 1925 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn | DATE OF BURIAL Jan 4 1925

20 UNDERTAKER Samuel A. Hawley | ADDRESS 1778 Baltimore

Spec.—1-10-21—M&T—1500 Blks.

D 93636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 13-5 129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Clara Wolman

(a) RESIDENCE NO. 2919 Parkwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Paul Wollman

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Ebenker

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Mother
(Address) [illegible]

15 Filed JAN 4 - 1925 19 REC'D H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2/25

17 I HEREBY CERTIFY, That I attended deceased from 12/17, 1924, to 1/2, 1925,
that I last saw her alive on 1/2, 1925
and that death occurred, on the date stated above, at 5:15 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia (terminal)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Philip Lenhard, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 1/4 19 25

20 UNDERTAKER Jack Levi's

ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93637

CERTIFICATE OF DEATH.

18-1 11 2

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 940 W.Franklin St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice C.Frick,

(a) Residence No. 940 W.Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of Isiah D.Frick,

6-DATE OF BIRTH (month, day and year) Feb.5.1865

7-AGE. 59 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edward D.Jones,

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Eliza E.Fose,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md.

14- (Informant) Isiah D.Frick,
(Address) 940 W.Franklin St.

15-
Filed ....., 192.. ROGER T. WALKER
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) JAN 3 - 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 2, 19.25, to Jan 2, 19.25,

that I last saw h.. alive on Jan 2, 19.25,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) 2 hours.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.

JAN 3 1925 (Address) 910 N. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL, Loudon Park DATE OF BURIAL, JAN 5 - 1925, 19..

20-UNDERTAKER Geo W Little ADDRESS 2708 EDMONDSON AVE.

JAN 4 - 1925 Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 93638

CERTIFICATE OF DEATH.

101-001 D 93638

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2628 Edmondson Ave St., 16-3 WARD)

2-FULL NAME Sarah Martha Waltjen

(a) RESIDENCE NO. 2628 Edmondson Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Henry Waltjen

6 DATE OF BIRTH (month, day, and year) August 8 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Stewart

11 BIRTHPLACE OF FATHER (city or town) Edinburg (State or country) Scotland

12 MAIDEN NAME OF MOTHER Permelia Lander

13 BIRTHPLACE OF MOTHER (city or town) Balto, Co, (State or country) Md.

14 Informant Gladys Waltjen (Address) 2628 Edmondson Ave.

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2 1925

17 I HEREBY CERTIFY, That I attended deceased from December 31, 1924, to January 2, 1925, that I last saw her alive on January 2, 1925, and that death occurred, on the date stated above, at 4:27 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) organic heart disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

1-2, 1925 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore

DATE OF BURIAL 1925 JAN 5 -

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 93639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 93639

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 210 Monastery Ave ST. 21-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Rebecca Jonske

(a) RESIDENCE. No. 210 Monastery Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert F. Jonske.

6 DATE OF BIRTH (month, day, and year) Oct 30 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Windeler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John W. Jonske (Address) 210 Monastery Ave

15 Filed . 19 ROBERT R. KRAUTER, Registrar

JAN 4 - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 19 25

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924 to Dec 28, 1924.

that I last saw h[illegible] alive on Dec 28, 1924.

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized arteriosclerosis

(duration) 3 yrs! mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Michel, M. D.

Jan 1 1925 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Carmel — Jan 4 1925

20 UNDERTAKER — ADDRESS

George Schwab — 1101 Pulaski St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

B 93640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 B 93640

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Calvert St.) (WARD 20)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcina Weisinger

(Residence in Baltimore: No. 112 S. Calvert St.) (If not, yrs., mos. ds.) 40

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 10, 1859. (Month) (Day) (Year)

7-AGE, 65 yrs. 1 mos. da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (none)
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Spitznagel

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Weisinger

(Address) 112 S. Calvert St.

15-

Filed JAN 4 - 1925 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2, 1925. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1924, to Jan. 2 1925, that I saw h[er] alive on Dec. 31 1924, and that death occurred, on the date stated above, at 7 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Influenza
Bronchial Pneumonia

(Duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(Duration) yrs. mos. da.

(Signed) E. S. Kerr M. D.

Jan. 3, 1925 (Address) 196 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Jan. 5, 1925

20-UNDERTAKER George L. Ishwar

ADDRESS 1101 Park Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 N. B'way ST., 4-357 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Nickle

(a) RESIDENCE NO. 1325 N. B'way ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Chas W. Nickle

6 DATE OF BIRTH (month, day, and year): Nov 11/69

7 AGE — Years: 55 — Months: 1 — Days: 21 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Thos Bunce

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Josephine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Chas. W. Nickle

(Address): 1325 N. B'way

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1st 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924, to Jan 1, 1925, that I last saw h-e alive on Jan 1, 1925, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Coma

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W Wiseman M. D.

1/3, 1925 (Address) 1800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Miss's Cemetery

DATE OF BURIAL: 1/4 1925

20 UNDERTAKER: Philip Herwig

ADDRESS 3116 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Lutman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93642

CERTIFICATE OF DEATH.

D 93642

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 Baldwin St., 13-39 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Leutman

(a) Residence No. 1517 Baldwin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 12 1924

7-AGE.	If LESS than 1 day,
....yrs. 1 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Homer Leutman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Emma Wood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Homer Leutman

(Address) 1517 Baldwin St

15- Filed JAN 4 1925 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 19 24 to Jan 3 19 25

that I last saw him alive on Jan 3 19 25

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemmorhage, Hemiplegia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) [illegible] M. D.

, 19 (Address) 2020 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Marys Hamp	Jan 5 19 25
20-UNDERTAKER. Ebenezer Lee	ADDRESS 3617 Chestnut Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93643

D 93643

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) 12 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F. Frizzell

(a) RESIDENCE No. 3033 Huntington Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C Frizzell

6 DATE OF BIRTH (month, day, and year) Nov 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) RR 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Anna C Frizzell

(Address) 3033 Huntington Ave

15 Filed ....., 19..... Registrar

JAN 4 - 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 2, 1925, that I last saw him alive on Jan 2, 1925, and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH* was as follows:

Acute Influenza

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? Yes Date of Dec 31-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. W. Dolley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL Jan 5 1925

UNDERTAKER Ehenow & Son ADDRESS Electric

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93644

CERTIFICATE OF DEATH.

44 D 93644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Avalon ave ST., 19-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Rice

(a) RESIDENCE No. 2313 Avalon ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 27/52

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) in market

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Laurens Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Catharine Kennright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Laura B. Steele

(Address) 2313 Avalon Ave

15 Filed JAN 4 1925 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1924, to Jan 1, 1925, that I last saw him alive on Dec 31, 1924, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

about 1 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Krumpf M. D.

(Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 5 1925
20 UNDERTAKER	ADDRESS
L. T. J. Schnorr & Son	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 93645

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 W. Lafayette Ave. St., 6 Ward)

Registered No.

2-FULL NAME Washington Boyd Stanton

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1917 W. Lafayette Ave. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Colton Stanton

6-DATE OF BIRTH (month, day and year): Jan 25 1871

7-AGE, 53 yrs. 11 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Buyer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Stewart & Co. Balto Md.

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, Norman Leslie Stanton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Co Md.

12-MAIDEN NAME OF MOTHER, Alice L. Rice

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Mr. Leslie C. Stanton

(Address) 1917 W. Lafayette Ave.

15-

Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 2 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1924 to Jany 2, 1925 that I last saw him alive on Jany 20, 1925 and that death occurred, on the date stated above, at 12.05 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Type 4

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulm tuberculosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Thos McElwaine Thomas M. D.

1/4, 1925 (Address) 330 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Jan 5 1925

20-UNDERTAKER: Wm J Pickney Sons ADDRESS: North Ave & Pa.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-22—M&T—100 Bks.

93646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13-90 VD 93646

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2603 Francis ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward B. Treadwell

(a) RESIDENCE No. 2603 Francis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida May Treadwell

6 DATE OF BIRTH (month, day, and year) Jan. 11 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U.R.&E. Co.

9 BIRTHPLACE (city or town) Harford Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Treadwell

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs Ida M Treadwell
(Address) 2603 Harfords St.

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D.
(Coroner.)

Jan 14 1925 (Address) 3532 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York. Pa.	Jan 5 1925

20 UNDERTAKER Wm J Tickner & Sons ADDRESS York Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

93647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Fly Hospital St., 27-9 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augt F. Johnston

(a) Residence No. Southern Hospital St., 673 Bonaiter Ave Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Augt Johnston

6-DATE OF BIRTH (month, day and year) Unknown.

7-AGE, About 84 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Bridget F. McCoy

(Address) 406 Bonaiter Ave Govans

15- Filed 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 3. 1925

17- I HEREBY CERTIFY, That I attended deceased from 10/21/22, 19.., to Jan 3, 19.25

that I last saw h.. alive on Dec 28, 19.24

and that death occurred, on the date stated above, at 3.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm F. Triplett M. D.

, 19 (Address) 1324 N Longwood St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Jan 6. 19.25

20-UNDERTAKER, W. J. Sudlow Sons ADDRESS Union

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93648

CERTIFICATE OF DEATH.

101-001 D 93648

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1015 Boyd St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Smith

(a) Residence No. 1015 Boyd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown.

7-AGE. 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: house work

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs Robert

(Address) 1015 Boyd St.

15- Filed 192

ROBERT R. KRAUTER, Registrar.

JAN 4 - 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3 1925

17- I HEREBY CERTIFY, That I attended deceased from 1/1/25 19 to 1/3/25 19

that I last saw h.. alive on 1/2/25 19

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Influenza

History (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Microscopic

(Signed) Bernard J Ferry, M. D.

1/3/ 1925 (Address) 96 W Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem

DATE OF BURIAL. Jan 5 19 25

20-UNDERTAKER. Peter J Conway & Son

ADDRESS 90 Wallace St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93649

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Probably 2421 E. Fayette St. 6-3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Engelberth

(a) RESIDENCE NO 133 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Engelberth

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Southern
(State or country) United States

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Frederick Engelberth
(Address) 133 N. Port St

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
JAN 4 1925
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 192 5

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Probably Valvular

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J S H Cullen, M. D.
(Coroner.)

Jan 4/25 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cemetery — DATE OF BURIAL Jan. 5 192 5

20 UNDERTAKER Mrs. E. Miller & Son — ADDRESS 2334 Jefferson Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93650 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH. + 131 D 93650

1-PLACE OF DEATH St. Joseph's Hosp Registered No.....

City of BALTIMORE: (No. ..... St., 9-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarice Mitchell

(a) Residence No. Ditchley va St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 13-1919

7-AGE. 5 yrs. 7 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Virginia
(State or Country).

PARENTS:
10-NAME OF FATHER, H C Mitchell
11-BIRTHPLACE OF FATHER (city or town)..... Virginia
(State or Country).
12-MAIDEN NAME OF MOTHER, Ema Sheriff
13-BIRTHPLACE OF MOTHER (city or town)..... Virginia
(State or Country).

14-
(Informant)..... Evelina Ditchley
(Address) 1324 Eutaw Place

15-
Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3-1925

17- I HEREBY CERTIFY, That I attended deceased from
Dec 27, 1924 to Jan 3, 1925
that I last saw h alive on Jan 3, 1925
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia until
Strokes in Kidneys
Bilateral
(Duration) 1 yrs. 6 mos. x ds.

CONTRIBUTORY
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 3-25

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G B Sybert M. D
19 (Address) 8 + Eutaw Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Ditchley va — DATE OF BURIAL: Jan 4. 1925

20-UNDERTAKER, J B Ayres Ditchley — ADDRESS 824 Eutaw Place

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93651

CERTIFICATE OF DEATH.

162 D 93651

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 S. Carrollton St.; 18-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mulcahy

(Residence in Baltimore: No. 11 S Carrollton Ave St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 1-2 (Month) (Day) 1925 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 8 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Balto MD.

PARENTS.

10-NAME OF FATHER, Joseph R. Mulcahy

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Hanson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Thompson

(Address) 11 Carrollton Ave

15-

Filed ..... 191.....

ROBERT R. KRAUTER, Registrar.

JAN 4 - 1925

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1-2- (Month) (Day), 1925 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-2 1925, to 1-2 1925, that I saw him alive on 1-2 1925, and that death occurred, on the date stated above, at 10½ P m.

The CAUSE OF DEATH* was as follows:

Atelectasis Fetal

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. Carr M. D.

1/3/25, 191... (Address) Franklin Sq. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel

DATE OF BURIAL, Jan. 5....., 1925

20-UNDERTAKER Wm. Wm. S. Finn's

ADDRESS 1737 N Pratt St

Spec.—8-24-14—M. & T.—2000 Bks.

Locke

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93652 ✓ D 93652

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Locke

(Residence in Baltimore: No. 1301 Argyle Ave St. Ref yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Oct. 4, 1863
(Month) (Day) (Year)

7-AGE, 61 yrs. 2 mos. 29 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Piano Polisher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hecht Bros & Co

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, John Lock

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna N. Finch

(Address) 112 Larch Drive, Hamilton

15-

Filed JAN 4 1925, 191... EMMA B. KRAMER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 2, 1925
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-30-1924, to 1-2-1925, that I saw him alive on 1-2-1925, and that death occurred, on the date stated above, at 11 55 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration).....yrs.....mos.....da.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) M. D. Parran M. D.

1/2/25, 191... (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....da. In the State .....yrs. .....mos. .....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Jan 5... 1925
20-UNDERTAKER	ADDRESS
Mrs Mrs. John W. Zeufel & Son	801 W. Fayette

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST. 16-6 WARD)

REGISTERED NO. D 93653

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

2-FULL NAME Anna Hufnagel

(a) RESIDENCE NO 3814 Mt. Pleasant ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 17/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Hufnagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Waechter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John Hufnagel
(Address) 3814 Mt. Pleasant

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd degree burns over body

(Dress caught fire from gas heater while playing with toys)

(Duration) yrs. moe ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Paitsel, M. D.
(Coroner.)

Jan 1/25 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Jan. 5 1925

20 UNDERTAKER Lilly & Ziler ADDRESS 403 S. Wolfe St.

MARKS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93654

CERTIFICATE OF DEATH.

188-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Penski (PENSKER)

(a) RESIDENCE NO 241 S. Chapel St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Penski

6 DATE OF BIRTH (month, day, and year) May 4/ 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Pauline Penski (Address) 241 S. Chapel St.

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Register Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1-1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull Dec 24/24

(struck by street car)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Parke, M. D. (Coroner.)

Jan 3/25 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 5 1925
20 UNDERTAKER	ADDRESS
Lilly & Zeile	403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-2 147 D 93655

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kreller

(a) RESIDENCE NO. 626 S. Ellwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of George Michael Kreller

6 DATE OF BIRTH (month, day, and year) June 4, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md (State or country)

PARENTS

10 NAME OF FATHER Ignatius Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Kreller - (Husband)

(Address) 626 S. Ellwood Ave

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 19 25, to Jan 2, 19 25, that I last saw her alive on Jan 2, 19 25, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) Nathan Jandorf, M. D.

Jan 4, 1925 (Address) 3635 Donnell Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 5 1925
20 UNDERTAKER	**ADDRESS**
Lilly & Zeiler	403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1884-885

D 93656

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. N. Hart

(a) RESIDENCE No. 1422 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie E Hart

6 DATE OF BIRTH (month, day, and year) July 24 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Geo Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Bessie E Hart
(Address) 1422 W Fayette

15 Filed JAN 4 - 1925, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Auto Accident

Inquest Pending

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey (Coroner.) M. D.

Jan 4th, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Lake Cem

DATE OF BURIAL Jan 5 1925

20 UNDERTAKER W M Routen

ADDRESS 238 N Howard

Spec—12-23-21—E.B.R.S.—400 Bks.

Johannes.

93657

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93657

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 N Linwood ave St., 7 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Julia A. Johanns

(a) Residence No. 715 N Linwood ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 23-1849

7-AGE, 5 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Fritz Adolph Johannes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). South Carolina

12-MAIDEN NAME OF MOTHER. Julia A. Finley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant). Fritz Johannes

(Address). 715 N. Linwood ave

15-Filed JAN 4 - 1925 ROBERT B. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 4, 1925

17-I HEREBY CERTIFY, That I attended deceased from June 3, 1925 to Dec 4, 1925

that I last saw him alive on Dec 3, 1925

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) ....yrs. ....mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. B. K. Campbell M. D.

Jan 4, 1925 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL, Jan 5, 1925

20-UNDERTAKER. Wm. C. Fuller & Son ADDRESS 2334 Jefferson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93658

CERTIFICATE OF DEATH. 100-00 | D 93658

20-4 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2690 Dulaney St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathiel B Wells

(a) Residence No. 2690 Dulaney St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 15 1859

7-AGE. 63 yrs. 5 mos. ds. IF LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Nathiel B. Wells

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Lenora Lansderman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Richard G. Wells

(Address) 1708 E. Lombard

JAN 4 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 2 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 19 24 to Jan 1 19 25

that I last saw him alive on Jan 1 19 25

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. X ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Jan 4. 1925 (Address) 2687 Dresden

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL. January 5 1925

20-UNDERTAKER. Kendall Pepper & Son — ADDRESS 37 S Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—[illegible] 100 Bks.

D 93659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25-4 85 D 93659

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

2-FULL NAME John F. Steinacker.

(a) RESIDENCE NO. #9 Maryland Ave. Westport ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widowed.

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary Steinacker.

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Chesapeake Iron
(c) Name of employer Works.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Steinacker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William Steinacker.(son).
(Address) #9 Maryland Ave. Westport.

15 Filed ....., 192.... Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 1st, 1925.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall down a stair way.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

Jan. 3rd, 1925. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident
#9 Maryland Ave Westport Dec. 31, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Jan 5 1925

20 UNDERTAKER Nelson E. Stiles — ADDRESS 320 Md Ave Westport

Spec.—1-10-21—M&T—1500 Bks.

D 93660

HEALTH DEPARTMENT—CITY OF BALTIMORE

57 D 93660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2149 W Lexington ST., 703 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H J Peddicord

(a) RESIDENCE No. 2149 W Lexington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Peddicord

6 DATE OF BIRTH (month, day, and year) July 7 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jamil Peddicord

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Vers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Mary A Peddicord 2149 W Lexington St

15 Filed JAN 4 - 1925 ROBERT R. RAMSTER Burial Permit Clerk 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 2, 1925.

that I last saw h[illegible]live on Jan 2, 1925

and that death occurred, on the date stated above, at 7-55 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thos E Daugherty, M. D.

Jan 3 1925 (Address) 1602 Polk St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/5/25
20 UNDERTAKER	ADDRESS
Kemp & Staley Fulton & Fayette	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 93661

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 1646 E 75th St., 9-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Grace Hardt

(a) Residence No. 1646 E 75th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hardt

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto Co. (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Baker

11-BIRTHPLACE OF FATHER (city or town) Littlestown (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Ellen Yingling

13-BIRTHPLACE OF MOTHER (city or town) Westminster (State or Country), Md

14-

(Informant) Mrs Wm Hardt

(Address) 1646 E 75th St

JAN 4 1925

Filed 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 1-1925

17-I HEREBY CERTIFY, That I attended deceased from Sept 1 1924 to Jan 1 1925

that I last saw h.. alive on Jan 1 19 25

and that death occurred, on the date stated above, at 6.50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Burnstock M.D.

1-3-1925 (Address) 1531 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Pk Cem	Jan 5, 1925
20-UNDERTAKER.	ADDRESS
Wm J Lichtenwalner Sons	Md Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93662

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 N. Baltimore ST. 19-1 WARD)

2-FULL NAME Mary L. Wood

(a) RESIDENCE. No. 1630 W. Baltimore St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	1 day 14 hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlotte, N. C.

12 MAIDEN NAME OF MOTHER Lillian Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlotte, N. C.

11 Informant James Wood

(Address) 1630 W. Baltimore St

12 (Address)

JAN 4 - 1925

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1924 to Jan. 1, 1925

that I last saw h[illegible] alive on Jan. 1, 1925

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 months)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? History —

(Signed) John S. Rivers, M. D.

Jan. 2, 1925 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1-5-1925
20 UNDERTAKER H. C. Cummings Son	ADDRESS 517 N Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93663

CERTIFICATE OF DEATH.

14-90 D 93663

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 302 Mosher St. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME P. Wall Keech,

(a) RESIDENCE NO. 302 Mosher St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Keech

6 DATE OF BIRTH (month, day, and year) April 10,1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 945

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co.

PARENTS

10 NAME OF FATHER Thos. Keech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. P. Wall Keech

(Address) 302 Mosher St

JAN 4 - 1925

ROBERT R. KRAUSER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1, 1925

17

I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1924, to Jan 1, 1925, that I last saw him alive on Jan 1, 1925, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Acute dilitation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Edw. V. Coolahan, M. D.

, 19 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 6 1925

20 UNDERTAKER Robt G Turner Jr & Co ADDRESS 442 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93664

CERTIFICATE OF DEATH.

86 901 D 93664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. St. 10-1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Crate

(a) RESIDENCE NO. 947 ~~Bond~~ Forest St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov. 15 1899

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
25	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mail Clerk at B&O.
(b) General nature of industry, business, or establishment in which employed (or employer) 09
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman H Crate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rivea Yahel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant William E Peck
(Address) 947 Forrest St

Filed JAN 4 - 1926 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2, 1925

17 I HEREBY CERTIFY, That I attended deceased from 8/18, 1924, to 1-2, 1925, that I last saw h i m alive on 1-2, 1925 and that death occurred, on the date stated above, at 11:10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic otitis media

? (duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Leptomeningitis
Brain Abscess (duration) yrs. 4 mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 12/23/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jno A Symptimes M. D.

. 19 (Address) MD Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 5 1925

20 UNDERTAKER Robt J Jones Jr. ADDRESS 1462 W Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93665

CERTIFICATE OF DEATH.

7H-001

12 6

1-PLACE OF DEATH

City of BALTIMORE: (No.) 804 St Paul St., Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Evelyn Wheeler

(a) Residence No. 801 St Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Geo W. Wheeler.

6-DATE OF BIRTH (month, day and year): Aug 8 1845

7-AGE: 79 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: John B Glocker.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Isabel King

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant): Mrs Wm Wright

(Address): 851 St Paul St

15- JAN 4 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 3 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1924 to Jan 3 1925

that I last saw h[illegible] alive on Jan 2 1925

and that death occurred, at the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Apoplexy

(Signed) Walter C Baker M. D

1/3 25 (Address) 100 E 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Jan 5th 1925

20-UNDERTAKER: E A Friedfeld Jr

ADDRESS: 501 E 22 St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93666

CERTIFICATE OF DEATH.

100-001

D 93666

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 9-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Cresswell

(a) Residence No. 1316 Wint St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M Cresswell

6-DATE OF BIRTH (month, day and year) Nov 11, 1850

7-AGE, 74 yrs. 1 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of Industry, business, or establishment in which employed (or employer) Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Cresswell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-

(Informant) Municipal Hospital Records

(Address) Municipal Hospital

15-

Filed..... 19.. ROBERT P. KRAUTER, Registrar.

JAN 4 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-3-25

17- I HEREBY CERTIFY, That I attended deceased from 7-29, 1924, to 1-3, 1925, that I last saw him alive on 1-3, 1925, and that death occurred, on the date stated above, at 6.40 A. m. The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) Claude S. Grace M. D.

1-3, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL. Jan 5, 1925

20-UNDERTAKER. Wm Cork ADDRESS 502 E Lombard

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93667 ~~HEALTH~~ DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 90 D 93667

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2930 Wyman Parkway ST., 17-2 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Teal

(a) RESIDENCE No. 2930 Wyman Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma H Teal.

6 DATE OF BIRTH (month, day, and year): May 10, 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): House 016

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Archabald Teal.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Susan Moss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Edward G. Tolp

(Address) 2930 Wyman Parkway.

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1923, to Jan 3 1925.

that I last saw h[illegible] alive on Jan 2 1925

and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Ch. Endo Chondritis

(duration) 2 yrs. + mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter C Bacon, M. D.

1/3. 1925 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Jan 5 1925

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette Ave

Spec. 6-6-19 H. P. C. 2 Cert. Blks.

D 93668

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93668

CERTIFICATE OF DEATH.

129

REGISTERED NO. 83

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 N. Chester ST.; WARD)

2-FULL NAME Josephine B. Addis

(a) RESIDENCE. No. 1418 N Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Joseph H Addis

6 DATE OF BIRTH (month, day, and year): July 1861

7 AGE: Years 62 | Months 6 | Days 1 | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. Swearer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Georgiana Whilldin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Joseph H Addis 1418 N. Chester St

15 Filed JAN 4 1925, 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1924 to Jan. 2 1925

that I last saw her alive on Jan. 2 1925

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. Lee Mageas, M. D.

1.3.1925 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Jan 5th 1925

20 UNDERTAKER Wm. Cook ADDRESS 5022 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1031—M&T—1500 Blks.

D 93669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93669

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 S. Sharp St ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Bruce

(a) RESIDENCE No. 501 S Sharp St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sterling.

6 DATE OF BIRTH (month, day, and year) June 10 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	57	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Emma Rose Evans (Address) 501 S. Sharp

15 Filed JAN 4 - 1925 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1924, to January 4, 1925, that I last saw her alive on January 2, 1925, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Debility

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) R. O. Sellman, M. D.

Jan 4, 1925 (Address) Towson, Balto. Co. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Lawn — DATE OF BURIAL 6 1925

20 UNDERTAKER H. McCormick & Son — ADDRESS 502 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Dr Fellinger, 666 Washington Blvd.

Spec. 669-19—31,500—(1000 Blks.

D 93670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93670

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 West Cross ST. 71-3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Berenice L Coates

(a) RESIDENCE. NO. 831 West Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L Coates

6 DATE OF BIRTH (month, day, and year) Sept 10, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Jno F. Ogilvie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER Julia Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles L Coates (Address) 831 West Cross St

15 Filed JAN 4 - 1925 ROBERT F. KRAUSER Registrar

Asst. Record Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1924 to Jany 3 1925 that I last saw h[illegible] alive on Jany 3 1925 and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M G Fellinger M. D.

1/4. 1925 (Address) 666 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 1/7/25

20 UNDERTAKER Freeman Cook

ADDRESS 502 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93671

CERTIFICATE OF DEATH.

D 93671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin & Gy Sts. WARD 19 21)

REGISTERED NO. 183

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Erastus Jackson

(a) RESIDENCE NO Ronco Pa - Shot Self ST. WARD 1234 Bayard St

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Unknown~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Albert Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Albert Jackson Jr
(Address) Reams Va

15 Filed JAN 4 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 19 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Suicide - Shot self accidentally

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Jan 3, 1925 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reams Va — DATE OF BURIAL Jan 4 1925

20 UNDERTAKER Mc-Mc Sr St Church — ADDRESS 1737 N Paca

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-22-5

D 93672
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2314 W. Lanvale St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William E James.

(a) Residence No. 2314 W. Lanvale St St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 19 1910

7-AGE. 14 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William B James.

11-BIRTHPLACE OF FATHER (city or town) Belfast Ireland (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary L. Eder

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Baltimore

14-
(Informant) William B James
(Address) 2314 W. Lanvale st

15-Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/2/25

17- I HEREBY CERTIFY, That I attended deceased from 11/25, 19 24 to 12/31, 19 24

that I last saw h. alive on 12/31, 19 24

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro-Poliomyelitis
(Infantile Paralysis.)

(Duration) 0 yrs. 5 mos. 0 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) 0 yrs. 0 mos. 10 ds.

18-Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag.

(Signed) Robt. A. Krauter M. D.

, 19 (Address) 706 N. Howard St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cem'y — DATE OF BURIAL. Jan 6, 1925

20-UNDERTAKER. Geo J Ruth — ADDRESS 1735 Harford Ave

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 93673

CERTIFICATE OF DEATH.

D 93673

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Bond St. ST.; 7-1 WARD)

REGISTERED NO. C 164

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Rhinehart.

(Residence in Baltimore: No. 922 N. Bond St. St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F. | 4-COLOR OR RACE, Wh | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Jan 3, 1851. (Month) (Day) (Year)

7-AGE, 74 yrs. ... mos. ... ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Smith.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah ——

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Rhinehart

(Address) 922 N. Bond st

JAN 5 - 1925 Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 1st, 1925. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1924, to Jan 1 1925, that I saw h[illegible] alive on Jan 1 1925, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows: Intramural fibroma

(Duration) 3+ yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) 2 yrs. ... mos. 1 ds.

(Signed) Edward C. Kelly M. D.

Jan. 4, 1925 (Address) 922 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery | DATE OF BURIAL, Jan. 5th, 1925.

20-UNDERTAKER Johannah Brooks | ADDRESS 1004 Aisquith st

Spec—12-23-21—E.B.R.S.—400 Bks.

93674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 D 93674

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 E Church St., 22-2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Green

(a) Residence No. 27 E Church St., 22 Ward

(Usual place of abode)

Length of residence in city or town where death occurred A yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6-DATE OF BIRTH (month, day and year) Feb 10 1869

7-AGE, 55 yrs. ~~8~~ mos. ~~12~~ ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Frances Green

(Address) 27 E Church St.

15- JAN 5 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Check.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/2/25

17- I HEREBY CERTIFY, That I attended deceased from 12/31/ 19 24 to 1/2/ 19 25

that I last saw h... alive on 1/2/ 19 25

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. Morley M. D.

1/3/ 19 25 (Address) 608 Shark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Annapolis Md — DATE OF BURIAL, Jan 7 1925

20-UNDERTAKER, J. H. Brown & Son — ADDRESS 108 W Monument St.

Route W 73 A ERR

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93675

CERTIFICATE OF DEATH.

93675

1-PLACE OF DEATH City of BALTIMORE: (No. 2016-N-Calvert St., 12-5 Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minna Heldmann Pagenstecher

(Residence in Baltimore: No. 2016-N-Calvert St.; yrs. 67 mos. 4 ds. 29)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: August (Month) 5 (Day) 1857 (Year)

7-AGE: 67 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS:

10-NAME OF FATHER: Joel Heldman

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Louisa Klock

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Heber - Son-in-law

(Address) 1315-N-Calvert St.

15-Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan 3 (Month) (Day) 1925 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ... M. D. (Coroner.)

Jan 5 1925 (Address) 2132 Boulevard

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? ? ? ?

Former or usual residence 2016 N Calvert

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Family DATE OF BURIAL: Jan 7 1925

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

Hubert G. Outerbridge

HEALTH DEPARTMENT—CITY OF BALTIMORE

93676

CERTIFICATE OF DEATH.

74-001

D 93676

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 Aisquith St., 5-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hebert G. Outerbridge

(a) Residence No. 207 Aisquith St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 15, 1834

7-AGE. 90 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Seaman

(b) General nature of industry, business, or establishment in which employed (or employer). & trade 08

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Bermuda, W. I.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), W. I.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), W. I.

14-

(Informant) Mary Hamby

(Address) 207 Aisquith St

15-

Filed..... 192.....

JAN 5 - 1925

ROBERT R. KRAMER

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3/25

17. I HEREBY CERTIFY, That I attended deceased from June 2 19 24 to Jan 2 19 25

that I last saw h-e alive on Jan 2 19 25

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

8 hrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

Infirmity (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Jakes M. D.

Jan 4, 1925 (Address) 1613 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cem. DATE OF BURIAL. Jan 6, 1925

20-UNDERTAKER. S. Theodore White ADDRESS 1128 Pulaski

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Bks.

D 93677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 93677

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 Wilcox St., 9-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mercedes M. Fellers

(a) Residence No. 1308 Wilcox St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced (or) WIFE of Harry F. Fellers

6-DATE OF BIRTH (month, day and year) Oct. 13 1883

7-AGE. 41 yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS

10-NAME OF FATHER. John J. Mooney

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. [illegible] Cullen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Harry F. Fellers

(Address) 308 Wilcox

15- Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 4 1925

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1924 to Jan 4 1925

that I last saw h. alive on Jan 3 1925

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 244 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 7, 1925
20-UNDERTAKER, Henry Hoerdt Son	ADDRESS 301 E Eager St

WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93678

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 4603 Harford Rd. St. 27-12 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Emilie Buchwald

(a) Residence No. 4603 Harford Rd. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, (HUSBAND of or) WIFE of Paul R. Buchwald

6-DATE OF BIRTH (month, day and year) Sept. 19 1857

7-AGE, 67 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

14- (Informant) Mrs. Paul R. Buchwald

(Address) 4603 Harford Ave.

15- Filed ..... 19.. JOSEPH R. KRAUTER, Registrar.

JAN 5 - 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jany 2-1925

17- I HEREBY CERTIFY, That I attended deceased from March 13 ....., 19 24, to Jany 2 ....., 19 25, that I last saw h alive on Jany 1 ....., 19 25 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia
(Cerebral Hemorrhage)

(Duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 2 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green M. D.

1/2, 1925 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery — DATE OF BURIAL. Jan. 5, 1925

20-UNDERTAKER. Henry Hoeck Son — ADDRESS 1301 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93679

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

D 93679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 1009 Somerset. St., 10 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Zang

(a) Residence No. 1009 Somerset St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced (HUSBAND) of (or) WIFE of: late John C Zang

6-DATE OF BIRTH (month, day and year): June 16 18[illegible]

7-AGE: 64 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS

10-NAME OF FATHER: Ferdinand Kerchner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Anna B. Simon Kemper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant): Mrs Anna M Zang

(Address): 1009 Somerset St

Filed JAN 5 - 1925 19.. ROBERT R. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 3 1925

17- I HEREBY CERTIFY, That I attended deceased from December 30 1924 to January 3 1925

that I last saw her alive on January 1 1925

and that death occurred, on the date stated above at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Toxemia
(Duration) .... yrs. .... mos. 1 ds.

CONTRIBUTORY (Secondary): Influenza
(Duration) .... yrs. .... mos. 5 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical Examination

(Signed) William A Schwartz M. D

1/2 1925 (Address) 1200 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemy	Jan 6, 1925
20-UNDERTAKER.	**ADDRESS**
Henry Hook Son	1301 E Lexington

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93680

CERTIFICATE OF DEATH.

+155 D 93680

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Genl Hospl. 24-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME EMMA GRACE HENDRICKS

(a) RESIDENCE NO. 414 EAST E ST. SPARROWS POINT MD WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	WHITE	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) SEPT 22 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) SPARROWS POINT MD

PARENTS

10 NAME OF FATHER RALPH C. HENDRICKS.

11 BIRTHPLACE OF FATHER (city or town) (State or country) GREEN CASTLE PA.

12 MAIDEN NAME OF MOTHER EVE STRASBAUGH

13 BIRTHPLACE OF MOTHER (city or town) (State or country) STEELTON PA.

14 Informant RALPH C. HENDRICKS

(Address) 414 EAST E ST SPARROWS PT.

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 3, 1925

17

I HEREBY CERTIFY, That I attended deceased from SEPT 5, 1924, to JAN 3, 1925,

that I last saw her alive on JAN 3, 1925

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

OSTEOMYELITIS OF LEFT TIBIA

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) SEPTICAEMIA

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? YES Date of SEPT 5/24

Was there an autopsy? NO

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. E. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cumberland Pa Via Penn R.R. DATE OF BURIAL: JAN 7 1925

20 UNDERTAKER: John F Denny ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93681

CERTIFICATE OF DEATH.

17 D 93681

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 300 Colegate Ave, 26-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora A Strumke

(a) Residence No. 300 Colegate Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm Strumke

6-DATE OF BIRTH (month, day and year) Dec 25 1875

7-AGE 49 yrs. - mos. 7 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Co Md

PARENTS

10-NAME OF FATHER Christ Foulty

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Mary Jane Weaver

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Co Md

14- (Informant) William S Strumke

(Address) 300 Colegate Ave Baltimore Md

15- Filed JAN 5 - 1925 ROBERT R. KRAUSER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 1 1925

17- I HEREBY CERTIFY, That I attended deceased from Oct 1923, to Jan 1 1925

that I last saw he alive on Jan 4 1925

and that death occurred, on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

Arteriosclerosis.

(Duration) more than 1 yrs mos. ds.

CONTRIBUTORY (Secondary) Uremia Coma

(Duration) yrs. mos. 24 hrs.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. McCormick M. D.

, 19 (Address) Dundalk Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn

DATE OF BURIAL, Jan 5, 1925

20-UNDERTAKER. John F Dorsey

ADDRESS 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital WARD) 5-2

REGISTERED NO. 193 D 93682

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Woodard.(C)

(a) RESIDENCE NO. 1414 Jefferson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, widowed, or divorced, HUSBAND of Charlotta Woodard.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Hod carrier.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

035

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Woodard.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charlotta Woodard.(C) wife.
(Address) 1414 Jefferson St.

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autps (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Frost bite and moist gangrene of right hand and both feet. Infectious meningitis. Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Jany. 5th. 192 5 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Found ill in a woods Dec. 26th. 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 5 192 5

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS: 1725 Ashland Av.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

93683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 W. Lee St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick J. Mitchell

(a) Residence No. 605 W. Lee St., 22 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Mitchell

6-DATE OF BIRTH (month, day and year) — — 1855

7-AGE, 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Y.M.C.A. & Church

9-BIRTHPLACE (city or town) (State or Country), Bermuda, B.W.I.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), B. W. I.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), B. W. I.

14- (Informant) Thos. F. Mitchell

(Address) 443 W. Pleasant St.

15- Filed JAN 5 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1/2/25

17- I HEREBY CERTIFY, That I attended deceased from 1/23/24 to 1/3/25, that I last saw him alive on Jan. 2nd, 1925, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Aneurism of Thoracic Aorta

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Finney Bowen, M. D.

1/3, 1925 (Address) 908 Asbury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Jan. 5, 1925

20-UNDERTAKER, Mrs. Geo. A. Hooper — ADDRESS 906 W. Conway st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93684 — 101-001 — D 93684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 Aiken Ave ST., 27-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bond Brooks

(a) RESIDENCE NO. 129 Aiken Ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin M. Brooks

6 DATE OF BIRTH (month, day, and year): Oct 8-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Co. Maryland

PARENTS

10 NAME OF FATHER: Thomas Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co. Md

12 MAIDEN NAME OF MOTHER: Isabel Shugart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Md

14 Informant (Address): Jos. Brooks Park Heights Ave

15 Filed JAN 5 1925 . 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1925, to Jan 3, 1925.

that I last saw h[illegible]ive on Jan 3, 1925,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Emory, M. D.

Jan 4, 1925 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Woodlawn Cem.

DATE OF BURIAL: Jan 6 1925

20 UNDERTAKER: Wm. C. Brooks

ADDRESS: Sparks

S·A·F·E

DARK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93685

CERTIFICATE OF DEATH.

B 93685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Virginia Ave - near Franklin) ST., 37 WARD)

REGISTERED NO. 55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Schneider

(a) RESIDENCE No. Aberdeen, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 3 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24th 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
63	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Farm

(b) General nature of industry, business, or establishment in which employed (or employer) Farm Work.

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country) Germany

PARENTS

10 NAME OF FATHER John Schneider

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Koch

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Anna Marie Wienecke
(Address) Virginia Ave. near Franklin

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3, 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2nd, 1925, to Jan 3, 1925.

that I last saw him alive on Jan 2nd, 1925

and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (a) Chr. Endocarditis (Mitral Lesion) 2 yrs and Acute Bronchitis ? yrs. mos. (a) 10 ds.

18 Where was disease contracted if not at place of death? At Aberdeen, Harford Co.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Valkenaar, M. D.

1-4, 1925 (Address) Rossville, Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 6 1925
20 UNDERTAKER	ADDRESS
H. Lansdale Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

D 93686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93686

CERTIFICATE OF DEATH.

9-7 X 117

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Kline

(a) Residence No. Fullerton, Md St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Kline

6-DATE OF BIRTH (month, day and year) Sept. 10th 1861

7-AGE. 63 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 037

(c) Name of employer.....

9-BIRTHPLACE (city or town). Balto. Co.

(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town). Unknown

(State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town). Unknown

(State or Country). Unknown

14-

(Informant) George Kline

(Address) Fullerton Md.

15-

Filed JAN 5 1925 ROBERT B. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 1924 to Jan 3 1925

that I last saw her alive on Jan 3 1925

and that death occurred, on the date stated above, at 12 40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Deg

Ac Cardiac Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac Appendicitis - Bronchitis

Cardiac hypertrophy - Arteriosclerosis & hyp

(Duration) yrs. mos. days

18-Where was disease contracted if not at place of death? Fullerton, Md.

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B Seybert, M. D

, 19 (Address) St Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph's Cemetery — DATE OF BURIAL Jan. 7th 1925

20-UNDERTAKER, Frank Krusa & Son — ADDRESS Fullerton

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

D 93687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 93687

REGISTERED NO. 93687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Linden Ave ST., 14-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Abrahams Parker

(a) RESIDENCE NO. 1714 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Widow.

6 DATE OF BIRTH (month, day, and year) Feb 13 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Woodward Abrahams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret F. Latty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lewis H. Farrington

(Address) Hampton Court Apts

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4th 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1924, to January 3rd, 1925;

that I last saw her alive on January 3rd, 1925;

and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac inefficiency,

of indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eduard C. Priel, M. D.

. 19 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	January 6 1925

20 UNDERTAKER Henry H. Jenkins Son & Co. ADDRESS Oxford & McCulloh Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93688

CERTIFICATE OF DEATH.

100-001

D 93688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Lancaster ST., V2 WARD)

2-FULL NAME Teofil Gutowski

(a) RESIDENCE NO. 1606 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 20-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child,

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER John Gutowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Helen Dombrowski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant John Gutowski, (Father)
(Address) 1606 Lancaster Street

15 Filed JAN 5 - 1925, 19 ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2. 1925.

17 I HEREBY CERTIFY, That I attended deceased from Dec 18. 1924. to Jan. 2nd 1925.

that I last saw him alive on Jan 1st 1925.

and that death occurred, on the date stated above, at 1.20 p m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam

(Signed) G T Teis, M. D.

Jan 3rd, 1925 (Address) 24 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. STANISLAUS CEMETERY — DATE OF BURIAL: I/5- 1925.

20 UNDERTAKER M. F. Sadowski, — ADDRESS 705 S. Ann St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20-001

D 93689

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Dillon ST.: 26-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wickman

(a) RESIDENCE. No. 3808 Dillon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 26. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Otto G. Wickman

11 BIRTHPLACE OF FATHER (city or town) Balts. (State or country) Md.

12 MAIDEN NAME OF MOTHER Esther Retterman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Otto G. Wickman
(Address) 3808 Dillon St.

15 Filed JAN 5 - 1925, 19 ... MEGT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from December 27, 1924, to Jan. 3, 1925, that I last saw him alive on Jan. 3, 1925, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Broumbas, M. D.

1-4, 1925 (Address) 3037 Edmondson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL Jan 7 1925

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93690 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 129 S. Linwood Ave St., Ward) 1-27-90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schmidt

(a) Residence No. 129 S. Linwood Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Adam Schmidt

6-DATE OF BIRTH (month, day and year): June 27-1839

7-AGE: 85 yrs. 6 mos. 8 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:
10-NAME OF FATHER: Not known
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12-MAIDEN NAME OF MOTHER: Not known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14- (Informant): Katharine Beacham
(Address): 129 S. Linwood Ave

15- Filed 1925 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 4-1925

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1924 to Jan 3 1925
that I last saw h. alive on Jan 3 1925
and that death occurred, on the date stated above, at 2.30 A m.
The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
(Duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D
Jan 4 1925 (Address) 839 S. Ellwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem. | DATE OF BURIAL: Jan 7 1925

20-UNDERTAKER: Zirkler & Zirkler | ADDRESS 1739 Eager

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93691

CERTIFICATE OF DEATH.

46 D 93691

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 N. Schroeder ST., 18-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie E. Base

(a) RESIDENCE NO. 329 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel F. Base

6 DATE OF BIRTH (month, day, and year) Aug 29 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Daniel Base

(Address) 4105 Seton Ave

Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1924 to Jan. 4 1925.

that I last saw her alive on Jan. 3 1925,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus & bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P.E.

(Signed) Homer E. Good, M. D.

1/4. 1925 (Address) 735 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 6 1925
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2175 Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

93692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1925 D 93692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 26-5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Steigerwald

(a) RESIDENCE NO 3226 Myrtle Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Steigerwald

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73 -5			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER //// Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John F. Steigerwald (son)
(Address) 3226 Myrtle Place

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 25

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Failure-Pulmonary Odema
(Fell down stairs-fracture of femur accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. M. Collins, M. D.
(Coroner.)

1-5-25 192 (Address) 508 E orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL Jan 5, 1925

20 UNDERTAKER John A. Moran — ADDRESS 3008 E. Balto

DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

D 93693

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1254 Washington Blvd. St., 21-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Eyerly

(a) Residence No. 1254 Washington Boulevard Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John H.Eyerly

6-DATE OF BIRTH (month, day and year) May 15,1852

7-AGE: 72 yrs. 7 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: George W.Purper

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): United states

14- (Informant): John H. Eyerly

(Address): 1254 Washington Blvd.

15- JAN 5 - 1925 Robert R. Kramer Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 2nd 25

17- I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Jan. 2, 1925, that I last saw h. alive on Jan. 2, 1925, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchc. Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Syncope

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Robert Keech, M. D.

1-3, 1925 (Address) 305 N. Calhoun Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL, Jan. 5" 1925

20-UNDERTAKER: Joseph B. Cook

ADDRESS 1003 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 93694

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 2137 West North Ave. St., 15-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Jerusa Anne Hughes

(a) Residence No. 2137 West North Ave. St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Evan R. Hughes

6-DATE OF BIRTH (month, day and year) Apr. 3rd 1844

7-AGE, 80 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Howard Co.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Isaac P. Ijams

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Cecilia Blake

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) William P. Hughes

(Address) 2740 Maryland Ave.

15- Filed JAN 5 1925 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 2 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1924 to Jan 2nd, 1925, that I last saw h.r alive on Jan 1st, 1925, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

.....(Duration)...yrs...mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

.....(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas, M. D.

1/2, 1925 (Address) 830 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Loudon Park Cem	Jan 5, 1925
20-UNDERTAKER, Joseph B Cook	ADDRESS 1003 W. Balto.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT [illegible] OF BA[illegible]

D 93695

CERTIFICATE OF DEATH.

D 93695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 16 b WARD)

2-FULL NAME Irvin E. Martz.

(a) RESIDENCE NO. 418 S. 13th. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of [redacted] Lottie F. Martz.

6 DATE OF BIRTH (month, day, and year) June 29, 1892.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman.
(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Leon E. Martz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Ellen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Lottie F. Martz. (wife)
(Address) 418 S. 13th. St.

15 Filed ..., 192 ... Registrar

JAN 5 1925 ROBERT P. KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto W. Reinhardt (Coroner), M. D.

Jany. 5th. 1925 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? #4 Engine House Lexington St. 1/2/25.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 1/6 192

ADDRESS 201 Orleans

20 UNDERTAKER Phil. Henry

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93696

CERTIFICATE OF DEATH.

11-001

D 93696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 E. Oliver ST., 8-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius H. Niemeyer

(a) RESIDENCE NO. 2307 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced. HUSBAND of ~~(or) WIFE of~~ late Elizabeth A. Niemeyer

6 DATE OF BIRTH (month, day, and year) Dec 22/74

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Forrester Tailoring Co.

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Fred W. Niemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Wm. Niemeyer (Address) 2307 E. Oliver

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 3, 1925, that I last saw h alive on Jan 3, 1925, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

(Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) H. L. Hearn M. D.

Jan 4, 1925 (Address) 1301 N. Rut Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto — DATE OF BURIAL 1/6 1925

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 D 93697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST. 20-5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sarah Morrow

(a) RESIDENCE. NO. Home for the Aged of the M. E. Church ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Morrow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Etta Cuddy

(Address) 400 N Fulton ave

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 3. 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1924, to Jany 3, 1925, that I last saw her alive on Jany 1st, 1925, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ✓ yrs. ✓ mos. ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis.

(duration) ? yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon M. D.

1/3 1925 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Jan 5 1925
20 UNDERTAKER	ADDRESS
George J Smith	1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 93698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 93698

1-PLACE OF DEATH

City of BALTIMORE: (No. 1714 Moreland Ave Ward) 15-17

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie J. Palter

(a) Residence No. 1714 Moreland Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw. P. Palter

6-DATE OF BIRTH (month, day and year): Dec. 25, 1886

7-AGE: 38 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Geo. H. Hummel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Theresa Machran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Phila Md Pa

14-
(Informant): Mr. Edw. P. Palter
(Address): 1714 Moreland Ave.

15-
Filed JAN 5 - 1925 192
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 2 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 29, 1924, to Jan 2, 1925, that I last saw him alive on Jan 2, 1925, and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M Bernard Kent M. D

1/3/25 19 (Address) 626 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem | DATE OF BURIAL, Jan 6 1925

20-UNDERTAKER: Wm Pickney Sons | ADDRESS: North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93699

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2632 Maryland Ave St., 12-39 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward E. Elledge

(a) Residence No. 2632 Maryland Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Casey Elledge

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 45 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R. Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ky.

PARENTS.

10-NAME OF FATHER Daniel B. Elledge

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ky.

12-MAIDEN NAME OF MOTHER Orilla Young

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Anne Casey Elledge

(Address) 2632 Maryland Ave

15- Filed JAN 5 - 1925 1925 ROBERT R. KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3-1925

17- I HEREBY CERTIFY, That I attended deceased from Dec. 10 19 24 to Jan 3 19 25

that I last saw him alive on Jan 3 19 25

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis ?

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. M. Little M. D.

1/4 19 25 (Address) 1430 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL. Jan 6 19 25

20-UNDERTAKER. Chas. P. Ennis & Son

ADDRESS 118 W. Mt. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Suydam

HEALTH DEPARTMENT—CITY OF BALTIMORE

93700 D

CERTIFICATE OF DEATH.

D 93700

1-PLACE OF DEATH (Willetta Suydam) REGISTERED NO.

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Etta Suydam

(a) RESIDENCE NO. Elkridge - Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hector H. Suydam

6 DATE OF BIRTH (month, day, and year) Sept 24-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife - 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER William Posey -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cleveland Ohio -

12 MAIDEN NAME OF MOTHER Mary Breeden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Charlotte Suydam

(Address) Elkridge Md

15 Filed JAN 5 1925 19 CHAS. M. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 - 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 - , 1925 , to Jan 3 , 1925

that I last saw her alive on Jan 3 , 1925

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Pelvic peritonitis

Septicemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? None Date of —

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) Thos A Boughman, M. D.

, 19 (Address) Md Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 7 1925

20 UNDERTAKER Chas. P. Graves & Son ADDRESS 118 W Mt Royal ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 93701

CERTIFICATE OF DEATH.

90 B 93701

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mount Hope Retreat St., 28-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Rev. Hugo Victor

(a) Residence No. Mt Hope Retreat St., 28th Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. [redacted] mos. [redacted] ds. How long in U. S., if of foreign birth? Dont Recall ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 15 - 1842

7-AGE,	If LESS than 1 day,
83 yrs. 0 mos. 0 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Priest 018
(b) General nature of industry, business, or establishment in which employed (or employer)..... Religious Work
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (2)
(State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Victor

11-BIRTHPLACE OF FATHER (city or town) (2)
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, E. Von Ends

13-BIRTHPLACE OF MOTHER (city or town) (2)
(State or Country), Germany

14-
(Informant)... Records of Mt Hope.....
(Address)..... Baltimore Md

15-
Filed....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 5th 1925

17- I HEREBY CERTIFY, That I attended deceased from
Dec 15-24 19..., to Jan 5....., 19.25
that I last saw h. m alive on Jan 4....., 19.25
and that death occurred, on the date stated above, at 7.30 A.m.
The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

7 or Years 2 2 2 (Duration)... yrs.... mos.... ds.

CONTRIBUTORY (Secondary) Chr. Senile Psychosis

For Years (2) (2) (2) (Duration)... yrs.... mos.... ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of.....

Was there an autopsy? No.....

What test confirmed diagnosis?.....

Jan 5, 1925 (Signed) Frank J. Flannery M. D. (Address) Mt Hope Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral Cemetery	Jan 7— 19.25
20-UNDERTAKER,	ADDRESS
Chas J. Kraus & Son	1130 Mt Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. Every item of information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 93702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93702

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 918 N. Payson ST.: 16-4 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine C. Anderson

(a) RESIDENCE. No. 918 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow ~~Widow~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Anderson (deceased)

6 DATE OF BIRTH (month, day, and year): May 28 - 1867

7 AGE — Years: 57 Months: 7 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charleston S. C.

PARENTS

10 NAME OF FATHER: John Shanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Susan Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): J. E. Anderson 918 N. Payson St

15 Filed JAN 5 - 1925 19 Robert R. Kramer Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 4, 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1925, to Jan. 4, 1925, that I last saw her alive on Jan. 4, 1925, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
Cardio sclerosis (senile)
Chronic nephritis

(duration) several mos. ds.

CONTRIBUTORY (Secondary) Pulm'y oedema, infarct.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? phys. exam

(Signed) Sautus C. Taggott, M. D.

, 19 (Address) 1015 Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Jan 7 1925

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bkn.

Mattey

90 V

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93703

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1213 William. ST. 24-1 WARD)

REGISTERED NO. D 93703

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ambrose Hurst.

(a) RESIDENCE No. 1213 William. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - Gertrude Hurst

6 DATE OF BIRTH (month, day, and year) Dec 23rd 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
64	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Letter Carrier.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Hurst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Gertrude Hurst. (Wife)

(Address) 1213 Williams St

15 Filed JAN 5 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924 to Jan 2, 1925, that I last saw him alive on Jan 2, 1925, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis?

(Signed) John A. Schwenk, M. D.

, 19 (Address) 1334 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. Co. DATE OF BURIAL 1-6th-1925

20 UNDERTAKER Ed B Hoke ADDRESS 115 E Mt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 107 W.Conway St. ST. 22-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME Frank P.Collawn.

(a) RESIDENCE NO. 107 W.Conway St. ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 1 mos. ----- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If ~~married, widowed,~~ HUSBAND of (or ~~WIFE of~~) Mamie Collawn.

6 DATE OF BIRTH (month, day, and year) November 4,1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER John Collawn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Judy. ---------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Eula Miner.(daughter)(Riner)
(Address) 107 W.Conway St.

15 Filed JAN 5 - 1925, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) duration yrs. mos. ds.

(Signed) Otto M Reinhardt (Coroner.), M. D.

Jany. 5th. 1925 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL 1-7 1925

20 UNDERTAKER Ehrb Harle ADDRESS 115 E Hoffman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 93705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 401 S. Bouldin St., 26-5 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Day

(a) Residence No. 401 S. Bouldin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Day

6-DATE OF BIRTH (month, day and year) Sept 8. 1863

7-AGE. 61 yrs. 3 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Park Police 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John W. Day

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Rebecca Lyons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Elizabeth Day

(Address) 401 S. Bouldin St

15- Filed JAN 5 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3/25

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924 to Jan. 3, 1925

that I last saw him alive on Jan 3, 1925

and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank A. Beatty M. D.

Jan. 4, 1925 (Address) 3244 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL. Jan. 8, 1925

20-UNDERTAKER. L. Sander Sons — ADDRESS 1710 Eden St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 34 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dunn

(a) RESIDENCE NO. 628 S. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Grudey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records (Address)

15 Filed JAN 5 - 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1 1925

17

I HEREBY CERTIFY, That I attended deceased from 9-15 1924 to 1-1 1925

that I last saw him alive on 1-1 1925

and that death occurred, on the date stated above, at 9 25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative)
Extra-Systolic Arrhythmia
Myocardial Insufficiency

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) Claude S. Dunn, M. D.

1-1 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Southwood	Jan 5 1925

20 UNDERTAKER M. Fahey & Son. ADDRESS 1217 W. North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93707

CERTIFICATE OF DEATH.

90D 93707

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2427 Edmonson Ave (ST., ... WARD)

2-FULL NAME Jacob J Poe

(a) RESIDENCE NO. 2427 Edmonson St. Av WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Josephine Poe

6 DATE OF BIRTH (month, day, and year) July 16 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
55	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U S Navy Yard

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jacob Poe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Josephine Poe
(Address) 2427 Edmonson

15 Filed JAN 5 1925, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4th 1925.

17

I HEREBY CERTIFY, That I attended deceased from several months to Jan. 4th 1925.

that I last saw him alive on Jany. 3rd 1925.

and that death occurred, on the date stated above, at 3:30 A. m.

THE CAUSE OF DEATH* was as follows:

Tricuspid Valvular Stenosis & heart with anasarca & albuminuria. Subjective symptoms (duration) About 2 yrs. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) O. H. Hoffman, M. D.

1-4 1925 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bord Leuvre — DATE OF BURIAL Jan 6 1925

20 UNDERTAKER M Raby & Son — ADDRESS 627 W North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93708

STILL BIRTH No.

D 93708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5008 Beaufort Av | 16 | 1-001 REGISTERED NO.

WARD

2-FULL NAME Marian Hofmann

(a) RESIDENCE. No. 5008 Beaufort Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 31-1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	18 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ursula Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ursula Hofmann

(Address) 5008 Beaufort Av

Verified JAN 5 1925 19

Robert P. Harrison, Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 1, 1925, that I last saw h[illegible] alive on Dec 31, 1924, and that death occurred, on the date stated above, at 11 9 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Dwar, M. D.

19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
HOPKINS HOSPITAL	

20 UNDERTAKER [illegible] Baltimore Health Dept. ADDRESS JAN 3 1925

[illegible] Wm. S. Hopkins

JAN 5 1925

400

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93709

D 93709

CERTIFICATE OF DEATH.

REGISTERED NO. 82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Washington Boulevard ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Harvey

(a) RESIDENCE NO. 1125 Washington Boulevard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Harvey

6 DATE OF BIRTH (month, day, and year) March 18th 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
64	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Louis Follman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Harvey
(Address) 1125 Washington Blvd.

15 Filed JAN 5 - 1925 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1924, to Jan 3, 1925, that I last saw h[illegible] alive on Jan 2, 1925, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Multiple Hernias

(duration) yrs. 1 mos 19 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H H Hammett, M. D.

Jan 3, 1925 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Jan 7th 1925

20 UNDERTAKER: Geo Lambert & Son ADDRESS 649 W Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 219 S. Wolfe St., V-1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonina Soltysiak

(a) Residence No. 219 S Wolfe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Peter Soltysiak

6-DATE OF BIRTH (month, day and year): 5/18/1871

7-AGE: 53 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Frank Mazenska

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Katherine Lewandowska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-
(Informant): Peter Soltysiak
(Address): 219 S. Wolfe St.

15-
Filed ..... 192..... Robert P. Harrison, Registrar.
1925 Burial Permit Clerk.

N 5 - 1925

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 3, 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Jan 3, 1925, that I last saw h[illegible] alive on Jan 3, 1925, and that death occurred, on the date stated above, at 3 20 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ....yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary): Chronic Bronchitis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank Jamieson M. D.

Jan 4, 1925 (Address) 212 E Fairmount Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: January 6, 1925

20-UNDERTAKER: William F. Gaylord — ADDRESS: 1811 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93711

D 93711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. S. E. Cor. Calvert & 31st. St., St. 12 3 10 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Dudley Robbins Smith

(a) Residence No. S.E. Cor. Calvert & 31st. St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Betsy O. Bell

6-DATE OF BIRTH (month, day and year) Dec. 11, 1874

7-AGE, 50 yrs. 0 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chief Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) Bureau of Statistics

(c) Name of employer B. & O. R. R.

9-BIRTHPLACE (city or town) (State or Country), Newark, Ohio

PARENTS.

10-NAME OF FATHER James Henry Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York, N. Y.

12-MAIDEN NAME OF MOTHER, Adelia Dudley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do not know

14- (Informant) Miss. Mary S. Bell
(Address) Calvert & 31st. Sts.

15- Filed JAN 5 1925 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/3/25

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1924, to Jan 3rd, 1925, that I last saw him alive on Jan 3rd, 1925, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Toxemia. Etc.

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

5th (Signed) Carroll Packard M. D.

Jan 6, 19 (Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Jan. 6 1925

20-UNDERTAKER, H. W. Mears & Son — ADDRESS 805 N Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1524 N. Caroline St., 9-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Akers

(a) Residence No. 1524 N. Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William R. Akers

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE.	If LESS than 1 day.
52 yrs. ..... mos. ..... ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore
(State or Country): Maryland

PARENTS.

10-NAME OF FATHER, Henry Hesse

11-BIRTHPLACE OF FATHER (city or town): (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Taube

13-BIRTHPLACE OF MOTHER (city or town): (State or Country), Germany

14- (Informant) Charles Hesse
(Address) 710 E. Lexington St.

15- Filed ..... Robert P. Harrison, Registrar.

JAN 5 - 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 3, 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 3, 19 25, to Jan 3, 19 25, that I last saw her alive on Jan 3, 19 25, and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast Unknown.

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John R. Sanderson, M. D.

, 19 (Address) 1714 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cemetery	1/6, 19 25
20-UNDERTAKER. Henry W. Sears & Son	ADDRESS 805 N Calvert

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

...stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH ...sified. Exact statement of OCCUPATION is very important.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93713

CERTIFICATE OF DEATH.

100 001 D 93713

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 1-1 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie English

(a) RESIDENCE No. 1311 Mt. Royal ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B. English

6 DATE OF BIRTH (month, day, and year) Oct 10 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harrisburg (State or country) Penna

PARENTS

10 NAME OF FATHER Hannabal Buchler

11 BIRTHPLACE OF FATHER (city or town) Penna (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Penna (State or country)

14 Informant Mrs. Ethel Arend (Address)

15 Filed JAN 5 1925, 19 Robert P. HARRISON Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/25 19

17 I HEREBY CERTIFY, That I attended deceased from 1/3/25, 19 ..., to 1/5/25, 19 ..., that I last saw h[illegible] alive on 1/5/25, 19 ..., and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows: Bronchio-Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. W. Holley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Penna Harrisburg, Dauphin Co. — DATE OF BURIAL: Jan 8 1925

20 UNDERTAKER Wm. H. Cook — ADDRESS 512 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93714

CERTIFICATE OF DEATH.

D 93714

REGISTERED NO. 1525

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Jud. Gen. Hospital (WARD) 9-3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kinnear

(a) RESIDENCE NO. 3106 Montebello Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Kinnear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Naomi Stagmeir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Naomi Kinnear
(Address) 3106 Montebello Ave.

15 Filed JAN 5 - 1925 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1924, to Jan 5, 1925,

that I last saw h.. alive on Jan. 5, 1925,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Furunculosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Staphylococcus septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec 25, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operative + laboratory

(Signed) Wm A Foucar Allen, M. D.

, 19 (Address) Md Jan 11, 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan 8 1925

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Monument

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 3ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 664 W. Fayette St., 4-1 WARD)

REGISTERED NO. 18 D 93715

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry A Falos

(a) RESIDENCE No 664 W Fayette St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Don't Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant J. M. Bull Son
(Address)

15 Filed JAN 5 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry)~~ inquiry thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hospital Observation Typhoid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Blood poisoning and Pneumonia

(duration) yrs. mos. ds.

(Signed) W R Pennington, M. D.
(Coroner.)

1-5-, 1925 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Jan 6 1925

20 UNDERTAKER W. H. Cook ADDRESS 5 & E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93716

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 209 S. Pulaski ST., 20-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Maria Filippino

(a) RESIDENCE NO. 209 S. Pulaski ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Frank D. Filippino

6 DATE OF BIRTH (month, day, and year) April 10-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	46	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. H. Tribbe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Bufmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co., Md.

14 Informant Miss Marie Tribbe, (Address) 2142 Frederick Ave.

15 JAN 5 - 1925 Robert P. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924, to Jan 3, 1925, that I last saw h alive on Jan 3, 1925, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Embolism

(duration) yrs. mos. days

CONTRIBUTORY (Secondary) Myocarditis Chronic Interstitial

(duration) 7 yrs. mos. da.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

1925 (Address) 2027 Wood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	1/7 1925
20 UNDERTAKER Elmer St. Conklin	ADDRESS 424 E. Eager St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93717

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 222 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Raleigh

(a) Residence No. 3 W Montgomery St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Raleigh

6-DATE OF BIRTH (month, day and year) 1839

7-AGE 85 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Canada

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records.

(Address)

15- Filed Jan 5 1925 By Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1-2-25

17- I HEREBY CERTIFY, That I attended deceased from 1-7, 1924, to 1-2, 1925

That I last saw him alive on 1-2, 1925

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude C. Grace, M. D.

1-3, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Ridge Cemetery — DATE OF BURIAL, Jan. 6, 1925

20-UNDERTAKER, Harry H. Pitzle — ADDRESS 1531 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 5 - 1925

Spec.—1-10-21—M&T—1500 Blks.

D 93718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3416 Gwynn Falls Parkway ST., 155 WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur E. Sadler, Jr.

(a) RESIDENCE NO. 3416 Gwynn Falls Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Louise Gilpin Sadler

6 DATE OF BIRTH (month, day, and year): May 31 1892

7 AGE: Years 32 | Months 7 | Days 3 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Morlin Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha Goodhand

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Louise Gilpin Sadler

(Address): 3416 Gwynn Falls Parkway

15 Filed JAN 5 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1924, to Jan 3, 1925.

that I last saw him alive on Jan 3, 1925.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Walter S. Gilbert, M. D.

Jan 5/25 19 (Address) 2220 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dorrance — DATE OF BURIAL: Jan. 6 1925

20 UNDERTAKER: Horace A. Burgee — ADDRESS: 363 Falls Road

WITH INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. NAVAL ACADEMY

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93719

D 93719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Spence ST. 75-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Schindle

(a) RESIDENCE NO 1115 Spence ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Schindle

6 DATE OF BIRTH (month, day, and year) April 14/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Schindle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Schindle (Address) 1115 Spence St.

15 Filed JAN 5 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd —1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by the Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner.)

Jan 5, 1925 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Jan 6 1925

20 UNDERTAKER George L. Schnabel ADDRESS 110 Eutaw

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3-1 Ward) 100

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Wilder

(a) Residence No. 1139 Watson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Wilder

6-DATE OF BIRTH (month, day and year): ? ? 1857

7-AGE: 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-(Informant) Municipal Hospital Records

(Address)

15-Filed JAN 5 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1-3-25

17- I HEREBY CERTIFY, That I attended deceased from 2-21, 1923, to 1-3, 1925, that I last saw him alive on 1-3, 1925, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude C. Grace, M. D.

1-3, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Jan. 6, 1925

20-UNDERTAKER: H. E. Hughes — ADDRESS: 414 N. Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93721

CERTIFICATE OF DEATH.

11-17 D 93721

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 204 Dolphin St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Hudgins

(a) RESIDENCE NO. 204 Dolphin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hudgins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Port Royal Va

PARENTS

10 NAME OF FATHER James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Royal Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Richard L. Hudgins

(Address) 204 Dolphin St

15 Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924, to Jan 3, 1925, that I last saw h[illegible] alive on Jan 3, 1925, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 1 day

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Edw. J. Wheatley, M. D.

1/5, 1925 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ant Auburn Cem.

DATE OF BURIAL Jan 7 1925

20 UNDERTAKER Joseph A Farrell

ADDRESS 2392 Division

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93722

CERTIFICATE OF DEATH.

D 93722

1-PLACE OF DEATH

City of BALTIMORE: (No. 1715 Hollins St., 19-2 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rena Rossa Roe

(a) Residence No. 1715 Hollins St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Irving A Roe

6-DATE OF BIRTH (month, day and year) Aug 3-1867

7-AGE	If LESS than 1 day,
57 yrs. 5 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) St Johns
(State or Country), New Brunswick

PARENTS.

10-NAME OF FATHER, James Swift

11-BIRTHPLACE OF FATHER (city or town) N.B.
(State or Country),

12-MAIDEN NAME OF MOTHER, Annie Austin

13-BIRTHPLACE OF MOTHER (city or town) N.B.
(State or Country),

14-

(Informant) Irving A Roe

(Address) 1715 Hollins St.

15-

Filed JAN 6 - 1925 19 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 5 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 19 24, to Jan 5 19 25,

that I last saw her alive on Jan 4 19 25,

and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Anaemia Pernicious

(Duration) yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Barrett C Collins, M. D.

, 19 (Address) 1404 Linden Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Jan 8, 1925
20-UNDERTAKER,	ADDRESS
J H Ulrich	2008 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 93723

City of BALTIMORE: (No. 9720 E Lombard St., Ward) 16-6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clara L Sanders

(a) Residence No. 9720 E Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single, Married, Widowed, or Divorced~~ (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Geo R Sanders

6-DATE OF BIRTH (month, day and year): Jan 23 1856

7-AGE: 68 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(b) General nature of Industry, business, or establishment in which employed (or employer): home work

(c) Name of employer: home

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John Metzger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary E Kampe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): John F Sanders

(Address): 9720 E Lombard

15-

Filed Jan 6 1925 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/4/1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1924 to Jan 4 1925

that I last saw h[illegible] alive on Jan 4 1925,

and that death occurred, on the date stated above, at 8.15 P.m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstatial Nephritis (Duration) X yrs. 6 mos. X ds.

18-Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? same as Bright's Dis

(Signed) Jas L Emas M. D.

Jan 6, 1925 (Address) 248 So 3d St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL, Jan 7, 1925

20-UNDERTAKER: John Ellis — ADDRESS: 2 Woodlawn

93723

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93724

CERTIFICATE OF DEATH.

D 93724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 N. Dallas ST., 8-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Pool

(a) RESIDENCE No. 1105 N. Dallas St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernst Pool

6 DATE OF BIRTH (month, day, and year) Sept 21-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crew Va.

PARENTS

10 NAME OF FATHER Louis Branch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Willie Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ernst Pool (Address) 1105 N. Dallas St

15 Filed JAN 6 1925 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3-25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage-T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. F. H. Callin, M. D. (Coroner.)

1-5-25 192 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crew Virginia — DATE OF BURIAL Jan 6 1925

20 UNDERTAKER Mrs R. G. Elliott — ADDRESS 1725 Ashland ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93725 — 118-02 93725

CERTIFICATE OF DEATH.

D 93725

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. Provident Hospital St.; 14-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Brown

(Residence in Baltimore: No. 2103 Druid Hill Av St.; 2 yrs., ... mos., ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~ (Write word.) Single

6-DATE OF BIRTH, ... Jan (Month) 5 (Day), 1879 (Year).

7-AGE, 45 yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Riley Brown

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Della Atkinson

13-BIRTHPLACE OF MOTHER (State or Country), N. C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Brown

(Address) 2103 D. Hill Av

15-

Filed JAN 6 - 1925 ROBERT B. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 5 (Day), 1925 (Year).

17-I HEREBY CERTIFY, That I attended deceased from Dec 29 1924, to Jan 5 1925, that I saw him alive on Jan 5 1925, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration) ..... yr. ..... mos. 5 da.

CONTRIBUTORY (Secondary) Volvulus

(Duration) ..... yr. 5 mos. ..... da.

(Signed) ..... M. D.

Jan 5, 1925 (Address) 1413 D. Hill Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? 2103 D. Hill Av

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL, Druid Cemetery — DATE OF BURIAL, Jan 7, 1925

20-UNDERTAKER Mrs R. G. Elliott — ADDRESS 1723 Ashland Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

61 100 D 93726

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals of Bay View Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Williams

(a) Residence No. 410 No. Bethel St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1868

7-AGE. 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Mack Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Mrs. P. Champe M.D.

(Address) Bay View Hospital.

15- Filed JUN 6 - 1925 192 ROBERT R. KRAMER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1/3/25

17- I HEREBY CERTIFY, That I attended deceased from 12/26 1924 to 1-3 1925

that I last saw him alive on 1/3 1925

and that death occurred, on the date stated above, at 5 00 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jas. P. Champe M. D.

, 19 (Address) Bay View Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Ashley Cemetery

DATE OF BURIAL. June 7... 1925

20-UNDERTAKER Mack K. C. Elliott

ADDRESS 325 Ashland Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93727

CERTIFICATE OF DEATH.

1-1 129

REGISTERED NO. D 93727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Bank ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Orlikowski

(a) RESIDENCE NO. 2110 Bank St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. , mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or Wife of)~~ Josephine Orlikowski.

6 DATE OF BIRTH (month, day, and year) Mar. 12 84

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Orlikowski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Josephine Orlikowski.

(Address) 2110 Bank St

15 Filed JAN 6 - 1925 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1925, to Jan. 5 1925.

that I last saw him alive on Jan 4 1925

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows: Pneumonia (lobular)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Reiberger, M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Jan 8. 1925
20 UNDERTAKER	ADDRESS
M. J. Sadowski.	705 S. Ann St

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93728 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7th.St& 3rd.Ave.Fairfield. 25-8-57 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Moore.(C)

(a) RESIDENCE NO. 7th.St.& 3rd.Ave.Fairfields ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 0 40
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Randolph Moore.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Johnson.(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Robert Detler.(C)
(Address) 7th.St. Fairfield.

15 Filed JAN 6 - 1925 192 Robert A. Knabe, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jany. 5, , 1925 (Address) 1041 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt olivet Cemetery	Jan 6 1925
20 UNDERTAKER Edward Bryson	ADDRESS 1631 arlington st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 93729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S Decker Ave ST., 14 WARD)

2-FULL NAME Josephine Pruchniwski

(a) RESIDENCE No. 614 S Decker Ave ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 40 mos. da. How long in U. S., if of foreign birth? 50 yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacob Kujawa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michal Pruchniwski

(Address) 614 S. Decker ave

15 Filed JAN 6 - 1925 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1924, to Jan. 4, 1925, that I last saw her alive on Jan. 4, 1925 and that death occurred, on the date stated above, at 1.55 p m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma (acidosis)

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Diabetes Mellitus, chronic

Interstitial Nephritis (duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood urine & coma.

(Signed) Joseph Sokany, M. D.

, 19 (Address) 2124 Orleans Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 8 1925

20 UNDERTAKER Stephen L Frackowski ADDRESS 1800 N Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93730

CERTIFICATE OF DEATH.

1-49

D 93730

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Eutaw Place ST., 14-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Henry Thompson

(a) RESIDENCE NO. 1907 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alice B Thompson

6 DATE OF BIRTH (month, day, and year) Jan 2 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Joseph H. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Ellen E. Raly-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mr Alex Howard

(Address) Bel Air Md.

JAN 6 1925

Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 24 to Jan 5th 19 25

that I last saw h[illegible] alive on Jan 5th 19 25

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Carcama of lung

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No -

What test confirmed diagnosis? X-Ray

(Signed) E Bruhnhauser M. D.

1/6 1925 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury N. C. Jan 6 1925	19
20 UNDERTAKER Chas. E. Franck	ADDRESS 112 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

93731

HEALTH DEPARTMENT—CITY OF BALTIMORE

93731

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N Eden ST., 5-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rebecca Atkins

(a) RESIDENCE NO. 503 N Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Atkins

6 DATE OF BIRTH (month, day, and year): Jan 0 1853

7 AGE — Years: 71 Months: 11 Days: 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Essex Co. Va.

PARENTS

10 NAME OF FATHER: Benj. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co. Va.

12 MAIDEN NAME OF MOTHER: Sallie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co. Va.

14 Informant: Mary Goddard

(Address): 503 N Eden St

JAN 6 - 1925

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924, to Jan 3, 1925, that I last saw h[illegible] alive on Jan 3, 1925, and that death occurred, on the date stated above, at 8.05 A. m.

The CAUSE OF DEATH* was as follows:

Acute Congestion of Lungs

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Lemuel Stanley, M. D.

, 19 (Address) 385 Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 6 1925

20 UNDERTAKER: J. D. J. H. Rochester — ADDRESS: 1411 Eggleston

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

93732

HEALTH DEPARTMENT—CITY OF BALTIMORE

93732

CERTIFICATE OF DEATH.

11-00 2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 814 W 36 ST., 13 (WARD)

REGISTERED NO. 11-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Benedict Kailer

(a) RESIDENCE NO. 814 W 36 ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 7 mos. /- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Kailer

6 DATE OF BIRTH (month, day, and year) March 11-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mills

(c) Name of employer Mt Vernon-Woodbury Co

9 BIRTHPLACE (city or town) (State or country) Frederick Co

PARENTS

10 NAME OF FATHER James Kailer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co

12 MAIDEN NAME OF MOTHER Mary Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co

14 Informant Miss Emma Kailer

(Address) 814 W 36

15 Filed JAN 6 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 4 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1924, to Jan. 4, 1925, that I last saw h[illegible] alive on Jan 4, 1925, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) C. F. Campbell M. D.

(Address) 3701 Reed Alley 1/4 1925

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 7 1925

20 UNDERTAKER	ADDRESS
A. S. Marshall	3539 Reed

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D 93733

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 311 N. Mount St. Ward 19-1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aleck Campbell

(a) Residence No. 311 N. Mount St. Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Campbell

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Essex Co. Va — 1

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va —

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Virginia Ballard

(Address) 311 N. Mount St

15- Filed JAN 3 1925

RUDOLPH R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-3-26

17- I HEREBY CERTIFY, That I attended deceased from Dec 31. 1924 to Jan 3 1925

that I last saw him alive on Dec 31st 1924

and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. L. Nuckols M. D.

, 19 (Address) 130 S. Gilmor St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL, Pikesville Bonnie View — DATE OF BURIAL, 1-7-26

20-UNDERTAKER, Daniel Easton — ADDRESS 916 Pine

SHOULD BE FILLED OUT EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. Every item of information should be carefully supplied.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93734 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 14-1 +49 D 93734

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1828 Division St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Evans

(a) Residence No. 1828 Division St., Ward (If non-resident give city or town and State)
(Usual place of abode) Patapsco, Md.

Length of residence in city or town where death occurred 70 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Bessie Evans

6-DATE OF BIRTH (month, day and year) Feb 11/80

7-AGE. 44 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penn.

PARENTS.
10-NAME OF FATHER, Hezekiah Evans
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penn.
12-MAIDEN NAME OF MOTHER, Elizabeth Russell
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn

14- (Informant) Bessie Evans
(Address) Patapsco. Md.

15- Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 4, 25

17- I HEREBY CERTIFY, That I attended deceased from Dec 28 1924 to Jan 4 1925
that I last saw him alive on Jan 3 1925
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate
(Duration) 6 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. S. McCard M. D.
1/5, 1925 (Address) 2005 O'Sullivan

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Columbus Ohio — DATE OF BURIAL, 1-7-1925

20-UNDERTAKER. David Easton — ADDRESS 916 Eutaw

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 93735

101-001

D 93735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 Woodyear St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Carter

(a) Residence No. 1061 Woodyear St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~Single~~, Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Moe Carter

6-DATE OF BIRTH (month, day and year) ? 1869

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Va.

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, Dennis Tipshire

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Martha Tipshire

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Richard Carter

(Address) 100 Woodyear st

15- Filed JAN 6 1925 ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-4-25

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1924 to Jan 4 1925

that I last saw h-- alive on Jan 4 1925

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eubleam Fay M. D.

1/5 1925 (Address) 1938 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. 1-7-1925

20-UNDERTAKER. Daniel Easton

ADDRESS 912 Pa ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93736

1-PLACE OF DEATH

City of BALTIMORE: (No.) 73 Ridgley Street St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odessia Randolph

(a) Residence No. 73 Ridgley St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Negro

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 6-12-1924

7-AGE, yrs. 5 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Chas. H. Randolph

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Marie Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md.

14- (Informant) Marie Taylor

(Address) 73 Ridgley St

15- Filed JAN 6 1925 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 4th '25

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2nd 1925 to Jan. 4th, 1925

that I last saw h... alive on Jan 3rd. 24, 19...

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Uncomplicated)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of deat

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter P. Jackson, M. D.

, 19 (Address) 1615 Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL, June 6, 1925

20-UNDERTAKER: Samuel T. Hunsley ADDRESS 578 N Eden St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93737

CERTIFICATE OF DEATH.

31 D 93737

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 Presstman St., 15-13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Estella S. Ray

(a) Residence No. 1313 Presstman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~Write~~ the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Ray

6-DATE OF BIRTH (month, day and year) May 1, 1880

7-AGE. 44 yrs. ~~11~~ 5 mos. ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): at home 03
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Elijah Adams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaretta Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Mrs. Gladys Ray
(Address) 1313 Presstman St

15-JAN 6 - 1925 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/4/25

17-I HEREBY CERTIFY, That I attended deceased from 10/8 19 24 to 11/4 19 25
that I last saw h~~e~~r alive on 11/4 19 25,
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:

(a) Arteriosclerosis
(b) Phthisis Pulmonalis
(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. R. Leatherman, M. D
11/5, 19 25 (Address) 2132 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Lebanon — DATE OF BURIAL, Jan 7th, 1925

20-UNDERTAKER, Clarence E. Mayfield — ADDRESS 1364 Harlem

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Swails

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93738

CERTIFICATE OF DEATH.

100-D 93738

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 773 Sarah ann... WARD 4-1)

2-FULL NAME Katherine Swails

(a) RESIDENCE NO 773 Sarah ann... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colo	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	1	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None (M)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt City
(State or country)

PARENTS

10 NAME OF FATHER Albert Swails

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ann Massey

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ann Massey
(Address) R 3 Sarah Lane

15 Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 5 yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Cold

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D.

1-5, 1926 (Address) 1711 Sarah ann... (Grondel)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	Jan 6, 1925
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 722 Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93739

CERTIFICATE OF DEATH.

32 ✓ D 93739

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST.; 9k-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Teresa Oppel

(a) RESIDENCE NO. 1203 Bruce St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Oppel

6 DATE OF BIRTH (month, day, and year): Sept 16 1891

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
33	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Joseph McConnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Aide Dare

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs Sadler (sister)

(Address) 1327 Bruce St

Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924, to Jan 4, 1925, that I last saw her alive on Jan 4, 1925, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Bilateral Basal pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical-Pathological

What tests confirmed diagnosis?

(Signed) Dr Robert Wilson, M. D.

19 (Address) West Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: Jan 7 1925

20 UNDERTAKER: A. Howard Evans

ADDRESS: 38 E Fort Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93740

CERTIFICATE OF DEATH.

100-901 93740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Low ST. 5-W (WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Dentt

(Residence in Baltimore: No. 1111 Low St St.; ....yrs.....mos.....da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	widow

6-DATE OF BIRTH, 7 (Month) 8 (Day), 1873 (Year)

7-AGE,	If LESS than 1 day,
51 yrs.....mos.....ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic Dr.

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Chester

(Address) 1111 Low St.

15- JAN 6 1925

Filed.....192.....

WILLIAM R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) H (Day), 1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1925 to Jan 3 1925 that I saw h[illegible] alive on Jan 2 1925, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.....3.....da.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....dys.

(Signed) A. S. Houston M. D.

1/5, 1925 (Address) 733 Argyle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cem.	Jan 6, 1925
20-UNDERTAKER	ADDRESS
Jas. J. Y. Locks	1302 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93741

CERTIFICATE OF DEATH.

5 160

D 93741

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 501 Annapolis Ave ST. Brooklyn WARD 5

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger Chronister

(a) RESIDENCE. No. 501 Annap. ave ST. Brklyn WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 (Life) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Oct 4-1924

7 AGE — Years — Months 3 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Same Maryland

PARENTS

10 NAME OF FATHER: Hoyd E. Chronister

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary B. O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Hoyd E. Chronister

(Address): 501 Annapolis Ave

15 Filed JAN 6 - 1925 . 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1924 to Jan 4 1925

that I last saw h[illegible] alive on Jan 4 1925

and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 2 mos. days

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) Robert W. Johnson M. D.

. 19 (Address) Brooklyn Md Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Jan 6 1925
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62 100-801 B 93742

1-PLACE OF DEATH

City of BALTIMORE: (No. 2021 Jefferson St St., 62 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Cornelia C. McKee

(a) Residence No.... 2021 Jefferson St. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, Widowed or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) March 4 1849

7-AGE, 74 yrs. 10 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House helping

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Robert Bourbeis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Cornelia Ward

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant).. Robert N. Gorman

(Address)..... 1807 N. Duncan

15-

Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar.

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 3/25

17- I HEREBY CERTIFY, That I attended deceased from January 23, 1924, to January 2, 1925

that I last saw h. alive on January 2, 1925

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Ayd, M. D.

Jan 4, 1925 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Western	Jan 6, 1925
20-UNDERTAKER, Wendell Bayol & Son	ADDRESS 378 Hanover

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 922 S. First St. St., 26 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Welsch

(a) Residence No. 922 S. First St. St., 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Welsch.

6-DATE OF BIRTH (month, day and year) July 6-1865

7-AGE. 59 yrs. 5 mos. 29 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Foreman 673

(b) General nature of industry, business, or establishment in which employed (or employer). B. & O. R.R.

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Christopher Welsch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Elizabeth Bowers.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) Amelia Welsch

(Address) 922 S. 1st St.

15- Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 4-1925

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1924, to Jan. 4, 1925, that I last saw h.i.m. alive on Jan. 4, 1925, and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis - Sputum Ex.

(Signed) Eugene Zeiler, M. D.

1/6, 1925 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem. DATE OF BURIAL. Jan. 7-1925

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93744

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 26 W. Moale St. ST., 23-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron F. Ware.

(a) RESIDENCE No. 26 W. Moale St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or HUSBAND of Margaret Ware.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	65	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer) National Enameling
(c) Name of employer & Stamping Company.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER AAron F. Ware.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Thomas M. Johnson.
(Address) 211 S. First St. Brooklyn.

15 Filed JAN 6 - 1925 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jany. 5th. 192 5 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 1/6 192 5

20 UNDERTAKER J. Fenw. McCully ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93745

CERTIFICATE OF DEATH.

23-290

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1707 Clarkson St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edna M. Blottenberger

(a) Residence No. 1707 Clarkson St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 4 1913

7-AGE. 11 yrs. 2 mos. 0 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School girl

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Balto.
(State or Country), md.

PARENTS.

10-NAME OF FATHER. Herman J. Blottenberger

11-BIRTHPLACE OF FATHER (city or town). Md.
(State or Country),

12-MAIDEN NAME OF MOTHER. Lillian Glaser

13-BIRTHPLACE OF MOTHER (city or town). Md.
(State or Country),

14- (Informant). Mr. Blottenberger

(Address). 1707 Clarkson

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

JAN 6 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 4 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Jan 4 1925

that I last saw her alive on Jan 4 1925

and that death occurred, on the date stated above, at 5 45 pm

The CAUSE OF DEATH* was as follows:

a Bronchitis 1
Mitral regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Decortication

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) F. E. Smith M. D.

1/5 1925 (Address) 910 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 192
Mt. Olivet Cem	1/7 19 25
20-UNDERTAKER. J. Frew McCully	ADDRESS 130 E. Fort

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93746

CERTIFICATE OF DEATH.

D 93746

1-PLACE OF DEATH West Balto General Hospital

REGISTERED NO. 18-238

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 18 ST., WARD)

2-FULL NAME Mr William Pierie -

(a) RESIDENCE NO. 841 N Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L Pierie

6 DATE OF BIRTH (month, day, and year): Mar 7 - 1855

7 AGE: Years 69 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Clerk

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Gro

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: James Pirie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Isabella Munson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mary L Pierie

(Address) 2439 E Fairmount

Filed JAN 6 - 1925 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 4 1925

17

I HEREBY CERTIFY, That I attended deceased from 12/19/24, 1924, to Jan 4, 1925, that I last saw h~~im~~ alive on Jan 4, 1925, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Lues -

Mitral Insufficiency } Luetic

Aortic Roughening }

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral Embolism - Instantly

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Clement R. Manuel, M. D.

, 19 (Address) West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan 7 1925

20 UNDERTAKER: Robt J Turner Jnr — ADDRESS: 1402 W Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93747

CERTIFICATE OF DEATH.

90 D 93747

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 209 Valley-view Ave

CITY OF BALTIMORE: (No. ..... ST., 26-1 WARD)

2-FULL NAME Gaetanella Grau

(a) RESIDENCE NO. 209 Valley-view ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? 11 yrs. 10 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1917

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
7	10	18	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Cechs-Slovakia
(State or country)

PARENTS

10 NAME OF FATHER Peter Grau

11 BIRTHPLACE OF FATHER (city or town) Cechs-Slovakia
(State or country)

12 MAIDEN NAME OF MOTHER Aloisa Kotras

13 BIRTHPLACE OF MOTHER (city or town) Cechs-Slovakia
(State or country)

14 Informant Father
(Address) 209 Valley-view Ave

15 Filed JAN 6 - 1925 ROBERT R. KRAUSE Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1925

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to Jan. 3, 1925, that I last saw h W alive on Jan. 3, 1925, and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Mitral + aortic regurgitation aortic stenosis.

(duration) 6 yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. C. Dobihal M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL Jan 6 1925

20 UNDERTAKER Hunt & Groce Sons — ADDRESS Woodland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93748 100-001 D 93748

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Tuscha

(a) RESIDENCE NO. 1001 N. Dallas St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Tuscha

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Violet Kaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 6 1925, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924, to Jan 5, 1924, that I last saw him alive on Jan 5, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1001 N. Dallas St

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Walter B. Stewart M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 7 1925

20 UNDERTAKER Frank Brockbon — ADDRESS 1906 Eastlake

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93749

101-001

D 93749

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2620 Keyser ST.: 8th (WARD)

2-FULL NAME Isabella V. Pollock

(a) RESIDENCE. NO. 2620 Keyser ST., 8th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 8 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Robert B. Pollock

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Biggs

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Mr. Robert B. Pollock

(Address) 2620 Keyser St

15 Filed JAN 6 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1925, to Jan. 5, 1925

that I last saw her alive on Jan. 5, 1925

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. O. Rumpack M. D.

1-5-1925 (Address) 1512 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery. DATE OF BURIAL June 6 1925

20 UNDERTAKER Henry Wood Sons ADDRESS 1201 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93750

CERTIFICATE OF DEATH.

8 D 93750

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST. 10-2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E Ward

(a) RESIDENCE. NO. 841 E. Eager St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? Sup yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert. Ward.

6 DATE OF BIRTH (month, day, and year) July 23, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas P. Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Anna Gavrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Robt Ward

(Address) 841 E Eager St

15 Filed ..... 19 ..... Registrar

JAN 6 - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 19 24, to Jan 5, 1925, that I last saw h alive on Jan 5, 1925, and that death occurred, on the date stated above, at 7 45 p.m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Tull M. D.

1/6, 1925 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 6 1925
20 UNDERTAKER	ADDRESS
Henry Hoerle Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93751

CERTIFICATE OF DEATH.

74 D 93751

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. 7 ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sherman

(a) RESIDENCE NO. 614 N. Ellwood Ave ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Sherman

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Bay View Hospital (Address) Balt.

15 Filed JAN 6 - 1925 ROBERT T. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3. 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1924 to Jan 3 1925

that I last saw he alive on Jan 2 1925

and that death occurred, on the date stated above, at 12-8 9 m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Residual Hemiplegia

Central Thrombosis ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. F. Edmunds M. D.

1/7/25 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery. DATE OF BURIAL Jan. 7 1925

20 UNDERTAKER Harry H. Nitzke ADDRESS 1531 N Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93752

D 93752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1303 N. Lombard St.

REGISTERED NO. 124

CITY OF BALTIMORE: (No. 1303 N. Lombard St. ST. 19-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis H. Schueler

(a) RESIDENCE. NO. 1303 N. Lombard St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma R. Schueler (nee Ellis)

6 DATE OF BIRTH (month, day, and year) May 21. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Schueler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs Emma R. Schueler. (Address) 1303 N Lombard St

15 Filed ..... 19 ..... Registrar

JAN 6 - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1924, to Jan 3, 1925, that I last saw him alive on Jan 3, 1925, and that death occurred, on the date stated above, at 2:15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis. Chronic Myocarditis and Auricular Fibrillation (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. H. Triplett, M. D.

19 (Address) 1324 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 6 1925
20 UNDERTAKER	ADDRESS
Harry V. Metzke	1531 N Lombard St

Spec.—1-10-21—M&T—1500 Bks.

D 93753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 93753

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 Asquith ST., 9-T WARD)

2-FULL NAME Annie McGee

(a) RESIDENCE NO. 1332 Asquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank McGee

6 DATE OF BIRTH (month, day, and year): Dec 1853

7 AGE: Years 72 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Hamon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Julia C. Vick

(Address) 1332 Asquith St

15 Filed JAN 6 - 1925 19 WELLS R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 - 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1924, to Jan. 3, 1925,

that I last saw her alive on Jan. 3, 1925,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. F. Hardin, M. D.

(Address) 1216 N. Caroline St 1/3, 1925

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Jan 7 1925

20 UNDERTAKER: W. C. Maddox — ADDRESS: 914 Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93754

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-49 93754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md University Hospital ST., 13-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irwin Gardner.

(a) RESIDENCE NO. 706 W. 36th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Carmon Gardner

6 DATE OF BIRTH (month, day, and year) July 26/87

7 AGE Years: 52 Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paver. Gas Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address) Carmon Gardner 706 W 36th

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk

JAN 6 1925

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1925, to Jan 5, 1925,

that I last saw h alive on Jan 5, 1925,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) 3 yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Gastric Hemorrhage.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm Lowry Jr., M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL Jan 8 1925

20 UNDERTAKER Chenoweth & Son ADDRESS 3617 Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93755

1765755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. No-5 ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Ostrotski (Truedzieuski)

(a) RESIDENCE NO. 109 N. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Michael Ostrotski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 5 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924, to Jan 4, 1925, that I last saw him alive on Jan 4, 1925, and that death occurred, on the date stated above, at 7.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinomatosis, (primary in pancreas?)
Chronic nephritis.
Myocardial insufficiency.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Louis E. Martin M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus

DATE OF BURIAL Jan 7 1925

20 UNDERTAKER John Madeley

ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93756

D 93756

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Belvale St. 24-3 WARD)

2-FULL NAME Henry J. Freeder

(a) RESIDENCE NO. 1504 Belvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/18/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nicholas Freeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Marie Hildebrand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant N. Freeder

(Address) 1504 Belvale

15 Filed JAN 6 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7. 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 1924 to Jan. 7 1925, that I last saw him alive on Jan 2. 1925, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Imbecility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Weakness

Spasm of Glottis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Starr M. D.

(Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	1/6 1925
20 UNDERTAKER	ADDRESS
J. J. Foley & Sons	318 Lytle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93757

22-182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Port Covington.W.Md.R.R.Co. St., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C.Purby.(C).

(a) RESIDENCE NO. 817 China Street. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~[illegible] Widowed~~ Rena Purby.(C).

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer W.Md.R.R.Co.

9 BIRTHPLACE (city or town) (State or country) Calvert Co.Md.

PARENTS

10 NAME OF FATHER Thomas Purby.(C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co.Md.

12 MAIDEN NAME OF MOTHER Harriet Jones.(C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co.Md.

14 Informant Rena Purby.(C)(wife). (Address) 907 Peach Al.

15 Filed JAN 6 1925, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.3rd. 1925.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall overboard from a scow while at work.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M Reinhardt (Owner), M. D.

Jan 5th, 1925. (Address) 1011 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 7 1925
UNDERTAKER	ADDRESS
Jno. Geo. H. Hooper	406 W. Conway St

D 93758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 15-154

CITY OF BALTIMORE (No. 1373 N Gilmore ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence Winslow Stewart

(Residence in Baltimore: No. 1373 N Gilmore St.; yrs., mos. 2/ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male — 4-COLOR OR RACE, White — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Dec 16, 1924 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 21 ds. — If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Randolph Tomkinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jeane Bernard

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gene B Stewart

(Address) 1373 N Gilmore St

15- Filed JAN 6 1925, 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 15th, 1925 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale,

(Duration) ....yrs. ....mos. 2/ ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. F. Hennessy M. D. (Coroner)

Jan. 4, 1925 (Address) 2402 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt Lorey — DATE OF BURIAL, Jan 7th, 1925

20-UNDERTAKER Hanna Murphy — ADDRESS 1364 Ha

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93759

CERTIFICATE OF DEATH

D 93759

1-PLACE OF DEATH University Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Thompson

(a) RESIDENCE NO. Ellicott City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. A. Thompson Jr.

6 DATE OF BIRTH (month, day, and year) Aug 17. 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	31	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Andrew Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Laura Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Wm A. Thompson Jr. (Address) Ellicott City.

15 JAN 6 1925 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1924, to Jan 5, 1925,

that I last saw her alive on Jan 5, 1925,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Eclopsia Pregnancy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary infection ? Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ellicott City

Did an operation precede death? Yes Date of Dec 16. 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Buchness, M. D.

, 19 (Address) University Hospital.

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cemetery Ellicott City Md	Jan 7th 1925
20 UNDERTAKER	ADDRESS
Scott M. Stacy	Ellicott City

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93760

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. 21-3 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Paul Just

(a) RESIDENCE NO. 1039 Madeira ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Martha C Just

6 DATE OF BIRTH (month, day, and year) Nov 6. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	70	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Martha C. Just

(Address) 1039 Madeira St

15 Filed JAN 6 1925, 19 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924, to Jan 5, 1925, that I last saw him alive on Jan 5, 1925, and that death occurred, on the date stated above, at 9.55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum
Mitral and aortic insufficiency } duration not known
arteriosclerosis

(duration) yrs. 14 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Dec 16. 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Operation

(Signed) Clement R. Mossal, M. D.

, 19 (Address) West Baltimore General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Jan 8 1925

20 UNDERTAKER Jos Joerdens Son — ADDRESS 2173 N.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93761 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93761

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2111 Lyndhurst St., Ave. (Ward) 45-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Roberts

(a) Residence No. 2111 Lyndhurst Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maggie. Roberts

6-DATE OF BIRTH (month, day and year) Jan 26 1873

7-AGE, 51 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer)..... 072

(c) Name of employer People Life Insur Co

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, John W. Roberts

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Julia Carney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Alabama

14- (Informant) Maggie M. Roberts (Address) 2111 Lyndhurst Ave

15- Filed JAN 6 - 1925 Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 5 1925

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1924 to Jan 5 1925 that I last saw h[illegible] alive on Jan 4 1925 and that death occurred, on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Metastases to Liver

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 2 24

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) Harley Cole M. D.

1-26-25 (Address) 2202 Gorsuch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL, Jan 7 1925

20-UNDERTAKER, Jos Joerdens Son — ADDRESS 207 S. Paca

(Over)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93762 — CERTIFICATE OF DEATH. — D 93762

1-PLACE OF DEATH Church Home & Infirmary — Registered No. 92

City of BALTIMORE: (No. Broadway and Fairmount Ave St., 11-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Maas

(a) Residence No. Hotel Altamont (Usual place of abode) Baltimore, Md. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND ~~of (or)~~ WIFE of: Blanche D. Maas

6-DATE OF BIRTH (month, day and year): Dec. 18 1857

7-AGE: 67 yrs. 0 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Armiger & Co

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Bavaria

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): France

14-

(Informant): Chas. Maas

(Address): Swathmore. Pa

15-

Filed JAN 7 - 1925 Lucian A. Kraus, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 5 1925

17- I HEREBY CERTIFY, That I attended deceased from January 2 19 25 to January 5 19 25

that I last saw h.. alive on January 5 19 25

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Coronary Artery - Left

Infarct Left Ventricle

Perforated Myocardium - A. Cent.

Hours - per cardium (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ?

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Pathology

(Signed) John C. Norment M. D

19 (Address) Church Home & Inf.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Jan 6 1925

20-UNDERTAKER: Wm J Gickner & Sons — ADDRESS: N & Pa.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

93763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93763

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2318 Edendale Rd. ST., 42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brooks Boyle

(a) RESIDENCE NO. 2318 Edendale Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Widowed

6 DATE OF BIRTH (month, day, and year) September 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER S. Hussey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Miss Brooks Boyle

(Address) Atlantic City N.J.

15 Filed JAN 7 - 1925 ROBERT R. REMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 30 1924 to Jan 5 1925.

that I last saw her alive on Jan 5 1925

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

(a) Cerebral hemorrhage

(b) Pneumonia lobar

6 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) 2 days mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Jan 7 1925 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Jan 8 1925
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Sons	Edmondson Ave & Collington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

B 93764 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 93764

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4740 Park Heights Ave (ST.) 27-3 (WARD)

2-FULL NAME Alva C. Kinsey

(a) RESIDENCE. (Usual place of abode) No. 4740 Park Heights Ave ST. WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Cunningham Kinsey

6 DATE OF BIRTH (month, day, and year) Aug 10. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 87

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Charles A. Kinsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Margaret C. Kinsey 4740 Park Heights Ave

15 Filed JAN 7 - 1925 R. C. RAULEN, Registrar Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1924, to Jan 5th, 1925, that I last saw him alive on Jan 5th, 1925, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bubert M. D

19 (Address) 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Jan 8. 25 19

20 UNDERTAKER ADDRESS

John C. Mitchell 1201 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

93765

CERTIFICATE OF DEATH.

X 197 D 93765

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S Hugh St., 3-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Mendora

(a) RESIDENCE NO. 116 S. Hugh ST., WARD Italy
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mendora

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Salvador Mendora

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Tony Longla
(Address) 218 Aisquith St

15 Filed JAN 7 - 1925 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said August (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows: Suicide
Bullet Wound Cerebral
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock.
(duration) yrs. mos. ds.

(Signed) J. Steiner M. D.
(Coroner.)
Jan 4 1925 (Address) 1243 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 1/7/25 192

20 UNDERTAKER Joseph Abrams

ADDRESS 224 Bway

CAUTION is very important. See instructions on back of certificate. Exact statement of OCCU... carefully supplied. Abbreviations should not be used. Be sure that it may be properly classified. Exact statement of OCCU... stated in plain terms, so that it may be properly classified. Exact statement of OCCU... on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93766

CERTIFICATE OF DEATH.

D 93766

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 712 Ensor St., 10-W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Boswell

(a) Residence No. 712 Ensor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lottie Boswell

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steveder

(c) Name of employer

9-BIRTHPLACE (city or town) Washington
(State or Country) D C

PARENTS.

10-NAME OF FATHER Sammy Boswell

11-BIRTHPLACE OF FATHER (city or town) ?
(State or Country) Va

12-MAIDEN NAME OF MOTHER Laura Smiler

13-BIRTHPLACE OF MOTHER (city or town) Leesburg
(State or Country) Va

14- (Informant) Ernest Boswell
(Address) 623 Def. Ave S.W. Wash DC

15- Filed JAN 7 1925 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 4 '25

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924 to Jan 4, 1925 that I last saw h[illegible] alive on Jan 4, 1925 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
(Cancer uncommon)

(Duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) acute Bronchitis & pleurisy

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? urinary

(Signed) J. J. McKay M. D.

1-5, 1925 (Address) 1126 Druid Hill ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel cemetery — DATE OF BURIAL, Jan 7, 1925

20-UNDERTAKER, Edward Bryan — ADDRESS 1631 arlington ave

...nal ill should be ... applied.
... A USE OF ... that it may be properly classified.
... instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93767

CERTIFICATE OF DEATH.

90 D 93767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1604 E Pratt. ST., 3-V WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac. Jacobs.

(a) RESIDENCE NO 1604 E Pratt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Jacobs

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or, ...min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Leather Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 E. Pratt.

15 Filed JAN 7 - 1925 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Duration yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

Duration yrs. mos. 1 ds.

(Signed) G. L. Blades, M. D.
(Coroner)

12/7/24 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	1-7- 1925
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Pratt.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 15[illegible]a.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93768

CERTIFICATE OF DEATH.

D 93768

1-PLACE OF DEATH Hebrew Hospital. 20-6 REGISTERED NO. 111-60

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Bordensky

(a) RESIDENCE NO. 2114 Eutaw ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Bordensky

6 DATE OF BIRTH (month, day, and year) July 15 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physicians

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Abraham Bordensky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Greider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1409 E Balto

15 Filed JAN 7 1925 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6, 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924, to Jan 6, 1925, that I last saw h[illegible] alive on Jan 6, 1925, and that death occurred, on the date stated above, at 9.10 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Gastric ulcer

(duration) 24 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 5/25

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A Miller Jos Abramson, M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew [illegible]	Jan 7 1925
20 UNDERTAKER	ADDRESS
Jack Lewis	1409 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 93769 B 93769

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 N. Payson ST.: 15 WARD 12

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucile Lafayette

(Residence in Baltimore: No. 1529 N. Payson St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Child

6-DATE OF BIRTH, Nov. 9- (Month) (Day), 1923 (Year)

7-AGE, 1 yrs. 1 mos. 27 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER, Harry Lafayette

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Ida Segel

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto

15-

Filed JAN 7-1925 1925 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6, 1925 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 6, 1925, to January 6 1925, that I saw her alive on January 6 1925, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. da.

(Signed) M. S. O'Delia M. D.

January 6, 1925 (Address) 1575 N. Bentalou

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Wash Road

DATE OF BURIAL, 1-7-, 1925

20-UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93770

1-PLACE OF DEATH

City of BALTIMORE: (No. 1715 E Fairmount ave 6 1 90 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shifra Levinson

(a) Residence No. 1715 E Fairmount ave St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 70 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Max Neirman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Rachel Naretzkie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Max Levinson

(Address) 1127 E Balto st.

15-Filed JAN 7 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 6/25

17- I HEREBY CERTIFY, That I attended deceased from 1-6-, 1925, to 1-6-, 1925

that I last saw h.Er alive on 6-6-, 1925

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Mitral & aortic regurgitation failure of heart. Sudden dilatation of heart—

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senility and Sudden dilatation of heart—

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Solomon C. Rabiff M. D.

1/7, 1925 (Address) 116 W Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Herrlich Southern ave — DATE OF BURIAL, Jan 7, 1925

20-UNDERTAKER, Sol Linson & Bro — ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1110-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93771

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen. Hosp. ST., 8-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John J. Clemens

(a) RESIDENCE NO. 1530 W. Madison ST. N. Madeira St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs John Clemens

6 DATE OF BIRTH (month, day, and year) Jan 9, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrolman. gb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John George Clemens.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Pepperseck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. John Clemens

(Address) 1530 W Madison St

15 Filed , 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan-3, 1925 to Jan 6, 1925, that I last saw h[illegible] alive on Jan 6, 1925, and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of No -

Was there an autopsy? No -

What test confirmed diagnosis? Clinical -

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 8 1925
20 UNDERTAKER	ADDRESS
Henry Hood Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 D 93772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SOUTH BALTO GEN'L HOSP. 23-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MRS MARY KATHERINE GERBRICK

(a) RESIDENCE NO. 1628 LIGHT ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	MARRIED

5a If married, ~~widowed, or divorced~~ HUSBAND of, WM. H. GERBRICK

6 DATE OF BIRTH (month, day, and year) NOV. 1. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer) HOME

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTO MD —

PARENTS

10 NAME OF FATHER J. C. PETERS

11 BIRTHPLACE OF FATHER (city or town) (State or country) BALTO. MD.

12 MAIDEN NAME OF MOTHER MARGARET MORGAN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BALTO — MARYLAND

14 Informant WM H. GERBRICK (Address) 1628 LIGHT ST —

15 Filed JAN 7 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 5 19 25

17 I HEREBY CERTIFY, That I attended deceased from JAN 5, 19 25, to JAN 5, 19 25

that I last saw her alive on JAN 5, 19 25

and that death occurred, on the date stated above, at 4 50 P. m.

The CAUSE OF DEATH* was as follows:

UMBILICAL HERNIA -

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) STRANGULATION — SURGICAL SHOCK (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? YES Date of JAN 5/25

Was there an autopsy? NO

What test confirmed diagnosis? OPERATION —

(Signed) J. F. Sonnborn, M. D.

1/6, 19 25 (Address) 11 Rochelle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	1/8 19 25
20 UNDERTAKER	ADDRESS
J. Few McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93773

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SOUTH BALTO. GEN'L Hosp. WARD) 32-2

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES P. THOMPSON

(a) RESIDENCE NO. 828 S. CHARLES ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	WHITE	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) DEC. 4 1905.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work MACHINIST.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTIMORE MD.

PARENTS

10 NAME OF FATHER WILLIAM THOMPSON

11 BIRTHPLACE OF FATHER (city or town) (State or country) BALTIMORE MD.

12 MAIDEN NAME OF MOTHER E. BENTON

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BALTO MD

14 Informant WILLIAM THOMPSON
(Address) 828 S. CHARLES ST.

15 Filed JAN 7 1925, 19 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 6 1925

17

I HEREBY CERTIFY, That I attended deceased from DEC 29, 1924, to JAN 6, 1925

that I last saw him alive on JAN 6, 1925

and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

LOBAR PNEUMONIA.

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) STAPHYLOCOCCUS SEPTICAEMIA ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? HOME.

Did an operation precede death? NO Date of —

Was there an autopsy? YES.

What test confirmed diagnosis? AUTOPSY + BLOOD CULTURE

(Signed) J. H. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: 1/9 1925

20 UNDERTAKER: J. Fenn McCully

ADDRESS: 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93774

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 Chelsea Terr ST.: 15-5 WARD)

2-FULL NAME Mrs. Etta Spear

(a) RESIDENCE. NO. 2409 Chelsea Terrs ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew [redacted] Spear

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE: Years 75; Months 7; Days 15; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Smyrna Del.

PARENTS

10 NAME OF FATHER: Tony Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sussex Co. Del.

12 MAIDEN NAME OF MOTHER: Elizabeth Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del

14 Informant: Mrs Sherman

(Address) 2409 Chelsea Terrs

15 Filed JAN 7 - 1925 19 Registrar ROBERT L. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6 1925

17 I HEREBY CERTIFY, That I attended deceased from May. 1924, to Jan. 6 1925, that I last saw h-er alive on Jan. 6 1925, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis. Nephritis

"High Blood Pressure"

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Brain hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Coma Sudden Lapse of Cardiac

(Signed) Thos. H Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Smyrna Del.

DATE OF BURIAL: Jan 9 1925

20 UNDERTAKER: Wilson M. Shriver

ADDRESS: 1118 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 93775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45D 93775

1 PLACE OF DEATH 602 Brookwood Rd

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 602 Brookwood Rd St.: 28-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Jordan

(Residence in Baltimore: No. 68 yrs St.; 68 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Unknown (Month) 1 (Day), (Year)

7-AGE: 68 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Refer

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mrs. Mrs. Laughlin

(Address) 602 Brookwood Rd

15-

Filed ....., 191 ..... REGISTRAR

JAN 7 - 1925

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 4 (Day), 1925 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18, 1924, to Jan. 4, 1925, that I saw h-r alive on Jan. 4, 1925, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon
(Hepatic Flexure)

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Acute Intestinal Obstruction

(Duration) yrs. mos. 4 ds.

(Signed) Frank G. Dallam M. D.

Jan 5, 1925 [Address] 2838 Edmondson

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Forest Park Cemetery

DATE OF BURIAL: Jan 6, 1925

20-UNDERTAKER: Harry H. Nitzke

ADDRESS: 1531 W. Lombard St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93776

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

D 93776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Univ Ave & Georgetown Rd Morrell Park — Registered No.....

City of BALTIMORE: (No. 25-3 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Woodey

(a) Residence No. Univ Ave & Georgetown Rd St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna Woody

6-DATE OF BIRTH (month, day and year) Jan 4 1904

7-AGE, 21 yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gas Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles H. Woody

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie C. Fischer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-
(Informant) Charles A. Woody
(Address) Highland Ave Morrell Park

15-
JAN 7 1925
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/5/25

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 19 24 to Jan 5 19 25

that I last saw h. alive on Jan 5 19 25

and that death occurred, on the date stated above, at 1 04 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. ..... mos. 2 W. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Mitchell Dunn, M. D.

, 19 (Address) 1520 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Jan 8, 1925

20-UNDERTAKER, Harry A. Petrie — ADDRESS 1531 W. Lombard

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93777

CERTIFICATE OF DEATH.

25-2 1101-001 D 93777

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Louis Katzenbergen

(a) Residence No. Paradise Ave Catonsville St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mae Katzenbergen

6-DATE OF BIRTH (month, day and year) July 7. 1870.

7-AGE. 54 yrs. 5 mos. 28 ds. (If LESS than 1 day ....hrs. or....min.)

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mgr. Sales Dept.

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balt. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Louis E. Katzenbergen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Rose Mallen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14- (Informant) Mrs. James W. Katzenbergen

(Address) Paradise Ave. Catonsville

15- JAN 7 - 1925 ROBERT B. KRAMER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 4 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 30. 1924. to Jan 4. 1925.

that I last saw h.. alive on Sunday Jan 4. 1925.

and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. Klima, M. D.

, 19 (Address) St. Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral	Jan 6 1925
20-UNDERTAKER, Harry H. Nitzke	ADDRESS 1531 N. Fulton Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93778

CERTIFICATE OF DEATH.

5-2 90

REGISTERED No. C 93778

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 Mott ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Ballard

(Residence in Baltimore: No. 419 Mott St.; Rise yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 1 (Month) (Day), 1874 (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Myers

(Address) 419 Mott St.

15-

Filed JAN 7- 1925, 19..

Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 4 (Day), 1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1925, to Jan 3 1925; that I saw him alive on Jan 3 1925; and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

ch. myocarditis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. L. Hornstein M. D.

1/7, 1925. (Address) 733 Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ashley Cemetery — DATE OF BURIAL, Jan 8., 1925

20-UNDERTAKER Mrs K. G. Elliott — ADDRESS 723 Eastlake

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93779

90D 93779

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 15 N. Norris ST., 19-1 WARD)

2-FULL NAME John R. Brown

(a) RESIDENCE NO. 15 N. Norris ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Tillie Bramford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Belle Stearn (Address) 15 N. Morris St

15 Filed JAN 7 - 1925 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos B. Horton, M. D. (Coroner.)

Jan 5 1925 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. auburn cem.	Jan 7 1925
20 UNDERTAKER Adolphus Hasted.	ADDRESS 151 winters Ave. Catonsville Md.

INK—PLEASE, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

93780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 93780

1-PLACE OF DEATH Building Arson

CITY OF BALTIMORE: (No. S.W. Cor Fulton & Mosher St., 16-4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Waldo Martin

(a) RESIDENCE No. 1806 Biggs ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louise Elizabeth Martin

6 DATE OF BIRTH (month, day, and year) Oct 28-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer) N

(c) Name of employer National Enl Stamp Co

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md

PARENTS

10 NAME OF FATHER Adam S. Martin

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Mathew

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Louise Elizabeth Martin
(Address) 1806 Biggs ave

15 Filed JAN 7 - 1925 ROBERT A. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1924, to Jan 5, 1925, that I last saw him alive on Jan 5, 1925, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Circumstances

(Signed) J. Thomas Jenkins, M. D.

, 1925 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 1/8/25 19

20 UNDERTAKER Geo. Weber & Son 2583 ADDRESS Edmondson ave

(WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93781

CERTIFICATE OF DEATH.

D 93781
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 N. Durham St., 84 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. McPhail

(a) Residence No. 1215 N. Durham St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew McPhail

6-DATE OF BIRTH (month, day and year) Sept. 3 1846

7-AGE. 78 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Robt. Barnett.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Richmond Va

12-MAIDEN NAME OF MOTHER, McGuinn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), " "

14-

(Informant) Edw. F. McPhail

(Address) 1215 N. Durham St.

15-

Filed JAN 7 - 1925 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 5/25

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1925 to Jan 5 1925

that I last saw h[illegible] alive on Jan 4 1925

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

General Senility
apoplexy hypostatic
Pneumonia

(Duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) X yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) O. H. Barber M. D.

(Address) 928 E North Ave

Jan 6, 1925

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Am — DATE OF BURIAL, Jan 8 1925

20-UNDERTAKER, Geo M. Linn & Son — ADDRESS 811 N Howard

THIS IS A PERMANENT RECORD. Every item of this question must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93782

CERTIFICATE OF DEATH.

101-001 D 93782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Stricker ST., 16-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tomax

(a) RESIDENCE No. 1029 Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?Dec 25-79

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary Tolliver

(Address) 1529 Stricker St.

15 Filed ..... 19 ..... Robert N. Kramer Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1925, to Jan 5, 1925, that I last saw h[illegible] alive on Jan 5, 1925 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey M. D.

1-6, 1925 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Jan 7 1925

20 UNDERTAKER Sam'l V. Cleaveland

ADDRESS 1400 Madison

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 93783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1601 ✓

D 93783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Mosher ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Dorothy Lee and Henry Lee

(a) RESIDENCE. No. 1118 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 24

7 AGE — Years — Months — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dorothy Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Henry Lee Mosher

15 Filed JAN 7 1925 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5 1925

17 I HEREBY CERTIFY, That I attended deceased from 12/21, 1924, to 1/5, 1925, that I last saw h alive on 1/4, 1925, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ex Prematurity and Asphyxia

(7 months Child which Refused & Took Nourishment)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burk Clutter, M. D.

1/6, 1925 (Address) 2139 O'Donnell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Jan 7 1925
20 UNDERTAKER: Sam W. Chesnutt	ADDRESS: 1100 Mosher

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state

Cor —1-12-23— M&T—100 Bks.

93784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-09 D 93784

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hospital ST., 15-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Maichey

(a) RESIDENCE NO. 1323 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 45				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Samuel H. Chase & Son
(Address) 1400 W. Mulberry St.

15 Filed JAN 7 - 1925 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy, M. D. (Coroner.)

Jan. 6, 1925 (Address) 2502 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 7 1925

20 UNDERTAKER Sam'l H. Chase & Son ADDRESS 1400 W. Mulberry St.

IMPORTANT—ENTRIES MUST BE CAREFULLY AND FULLY MADE IN EVERY RESPECT. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be of importance. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93785 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospitals St., 8-38 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Ferrell or Farrell

(a) Residence No. 1323 N Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1867

7-AGE, 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS.

10-NAME OF FATHER, Laurence Corbett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Phelenia Dilton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New York

14- (Informant) Municipal Hospitals

(Address)

15- Robert F. Harrison, Registrar.

1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-5-25

17- I HEREBY CERTIFY, That I attended deceased from 11-5, 1924, to 1-5, 1925, that I last saw h.r. alive on 1-5, 1925, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

C.H.S. Syphilis (Cardiac) Vascular

Lobar Pneumonia — 2 ds.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude E. Evans, M. D.

1-6, 1925 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Chattanooga New York

DATE OF BURIAL, Jan. 8—, 1925

20-UNDERTAKER. Claude E. Evans & Son

ADDRESS 1111 W. Mt. Royal Ave

Exact statement of OCCUPATION is very important. AGE should be properly entered. It may be properly corrected. Back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93786

CERTIFICATE OF DEATH.

38

D 93786

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 18-1 WARD)

2-FULL NAME George Lewis

(a) RESIDENCE No. 830 W. Saratoga ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Sarah Lewis

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE: Years 29. Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant: Bay View Hospital (Address)

15 Filed JAN 7 1925, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1924 to Jan 4, 1925

that I last saw h live on Jan 3 1925

and that death occurred, on the date stated above, at 5:50 p.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cystitis (Suspected)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Serological

(Signed) A. F. Smith M.D.

1/4/25 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: JAN 7 - 1925, 19

20 UNDERTAKER ..... ADDRESS .....

Robert F. [illegible] Clerk

Registrar

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

G.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93787 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE: (No. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Bee

(a) RESIDENCE No. 1030 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE: Years 70. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant: Boy View Hospital (Address): City

15 Filed JAN 7 1925, 19 Robert P. Harrison, Registrar

(SEAL) Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1. 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1924, to Jan 1. 1925

that I last saw him alive on Jan 1. 1925

and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Contrib)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Psychosis and Delirium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. J. Adams, M. D.

1/7/25 19 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: JAN 7 1925 19

20 UNDERTAKER: Commissioner of Health

ADDRESS

For Wm. E. Fosdale

4

S.A.F.E.

RESERVED FOR BINDING

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93788

CERTIFICATE OF DEATH.

D 33788

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. 76-77 ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mogansfeski

(a) RESIDENCE NO. Unknown ST. WARD

(Usual place of abode) Unknown

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 45. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 687

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Do

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital City

15 Filed JAN 7 1925, 19 Robert F. Harrison, Registrar

By [illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924 to Jan 4, 1925

that I last saw h[illegible] alive on Jan 3, 1925

and that death occurred, on the date stated above, at 4-30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis, Mania Potus

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. H. Adams M. D.

1/4/1925 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JAN 7 1925

20 UNDERTAKER: [illegible] for Health,

ADDRESS

For Wm. F. WOOBALL

KODAK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93789

CERTIFICATE OF DEATH.

D 93789

31

1-PLACE OF DEATH Municipal Tuberculosis Hosp. 1

CITY OF BALTIMORE: (No. Bay View ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Wood

(a) RESIDENCE NO. 622 Pin Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Harry Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 7 - 1925, Robert P. Harrison, Registrar

Burial Permit Issued [illegible] Asst Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1st 1925

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3rd, 1924, to Jan 1st, 1925,

that I last saw him alive on Jan 1st, 1925,

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 1 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. & Lab. findings

(Signed) J. T. White, M. D.

, 19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JAN 7 1925

20 UNDERTAKER

ADDRESS

For Wm. F. Turnbull, Director of Public Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 93790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 S. Linwood Ave ST., 1-2 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa G Wolf

(a) RESIDENCE NO. 133 S Linwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 9-1879

7 AGE — Years 45 — Months 11 — Days ..... — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer) Hutzler Bros

(c) Name of employer Same

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John B. Wolf

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Martha Mullin

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Maude Wolf
(Address) 133 S. Linwood ave

15 Filed JAN 7-1925 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) June 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924, to June 5, 1925,
that I last saw h[illegible] alive on June 5, 1925,
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? About city w/p

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 1438 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interbaltimore Cemetery — DATE OF BURIAL 1/8 1925

20 UNDERTAKER J. G. Moran — ADDRESS 3000 E. Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 93791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 Druid Hill ST., 1616 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Jones

(a) RESIDENCE NO. 1336 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Warner Jones

11 BIRTHPLACE OF FATHER (city or town) Northumberland Co. (State or country) Va

12 MAIDEN NAME OF MOTHER Melissa Campbell

13 BIRTHPLACE OF MOTHER (city or town) Northumberland Co. (State or country) Va

14 Informant Mrs. Melissa Jones (Address) 1336 Druid Hill

15 Filed JAN 7 - 1925 19 Robert [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6th 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 26th 1924 to Jan 6th 1925, that I last saw h alive on Jan 6th 1925 and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Edell, M. D.

19 (Address) 1224 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Jan 7 1925

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 N. Carey St.

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

(Altick)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93792

D 93792

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mount Hope Retreat St., 7847 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward C. Altick

(a) Residence No. Mount Hope Retreat St., 28th Ward Lancaster Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Altick

6-DATE OF BIRTH (month, day and year) Nov 26 - 1871

7-AGE.	If LESS than 1 day.
53 yrs. 1 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Hardware Salesman

(b) General nature of industry, business, or establishment in which employed (or employer). Selling Hdware

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Lancaster Pa

PARENTS.

10-NAME OF FATHER. Daniel Altick

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Lancaster Pa

12-MAIDEN NAME OF MOTHER. Mary Altick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Lancaster Pa

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Retreat

15- Filed 1925, 192.. Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7th 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 5th 19.. to Jan 7th, 19.25.

that I last saw h.. alive on Jan 6th, 19.25.

and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Paresis (Senile)

abt (Duration) 1 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (Duration) 1 yrs. 3 mos. 0 ds.

18-Where was disease contracted if not at place of death? Lancaster Pa

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

Jan 7th, 1925 (Signed) Frank J. Flannery, M. D. (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lancaster, Pa	1/9, 1925
20-UNDERTAKER.	ADDRESS.
H. S. Wilson & Sons	Pa Montclair

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 7

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 1 33 93793 — D 93793

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur D Pearson

(a) RESIDENCE NO. Norfolk Va ST., WARD Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. H. Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Missouri Segar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed JAN 7 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1925, to Jan 7, 1925, that I last saw h in alive on Jan 7, 1925, and that death occurred, on the date stated above, at 10:45 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor
semi-malignant
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? Yes Date of Jan 7 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Theobald M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL Jan 7 1925

20 UNDERTAKER John D Mitchell — ADDRESS [illegible] Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93794 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D. 93794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 Harford Ave St., 9-6 Ward) 29

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C. Seamann

(a) Residence No. 1607 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 7-1879

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plumber

(b) General nature of Industry, business, or establishment in which employed (or employer) Iron

(c) Name of employer own

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles A. Seaman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbara C. Wiegand

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs Barbara C. Seaman

(Address) 1607 Harford Ave.

15- Filed JAN 7-1925 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 5-25

17- I HEREBY CERTIFY, That I attended deceased from December 15 1924 to January 5 1925 that I last saw him alive on January 5 1925 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic interstitial Nephritis. (Duration)

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis + Complications of diseases (Duration) 8 yrs. mos. 11 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. G. W. Kennard M. D

1-6-1925 (Address) 708 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Garden Park Cemetery — DATE OF BURIAL, Jan. 8, 1925

20-UNDERTAKER, Geo. J. Rush — ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital 710-8 WARD 90)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Donnelly

(a) RESIDENCE NO. 1310 S. First ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Matilda Donley

6 DATE OF BIRTH (month, day, and year) Oct 10, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y.C

PARENTS

10 NAME OF FATHER John Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records (Address)

15 Filed JAN 7 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-4 1925

17

I HEREBY CERTIFY, That I attended deceased from 12-29, 1924, to 1-4, 1925

that I last saw him alive on 1-4, 1925

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension, Chronic Myocarditis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ex.

(Signed) Claude G. Dorsey, M. D.

1-5, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Jan 9 1925
20 UNDERTAKER W. Cook	ADDRESS 502 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PREPARED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93796

+155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto. E. E. & T. Hospital

CITY OF BALTIMORE: (No. 1214 Eutaw Place ST.: | WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Ardell Ruby

(a) RESIDENCE. No. Eldersburg, Md. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eldersburg
(State or country) Maryland

PARENTS

10 NAME OF FATHER Irving Ruby

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Jones

13 BIRTHPLACE OF MOTHER (city or town) Cooksville
(State or country) Howard Co. Md.

14 Informant Irving Ruby
(Address) Eldersburg Md.

15 Filed JAN 7 - 1925 19 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1925

17 I HEREBY CERTIFY, That I attended deceased from January 5 1925 to Jan. 7 1925
that I last saw she alive on January 7 1925
and that death occurred, on the date stated above, at 3:20 p.m.
The CAUSE OF DEATH* was as follows:
Mastoiditis, Chronic

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Meningitis (Purulent)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Jan 5, 1925

Was there an autopsy? No.

What test confirmed diagnosis? [illegible]

(Signed) Anthony C. Bonaffi (M. D.
, 19 (Address) Balt. E. E. & T. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Freedom Md.	Jan 9 1925

20 UNDERTAKER J. R. Neer ADDRESS Sykesville

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 93797

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93797

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1905 W. Mulberry St. ST. 20-3 WARD)

2-FULL NAME James E. Maxwell

(a) RESIDENCE NO. 1905 W. Mulberry St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1892

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman do

(b) General nature of industry, business, or establishment in which employed (or employer) Shipyard

(c) Name of employer Bethleham Steel Co

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Coleman R. Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Maryland

12 MAIDEN NAME OF MOTHER Daisy B McKitrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co, Maryland

14 Informant Mrs. Daisy B. Maxwell
(Address) 1905 W. Mulberry St.

15 Filed Jan 7 1925 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6, 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1925, to Jan 6, 1925, that I last saw h alive on Jan. 6, 1925, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmanary Tuberculosis

(duration) 4 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Oedma of lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edw V. Coolahan, M. D.

(Address) Edward V. Coolahan, M.D. 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 1/9/1925

20 UNDERTAKER J. Wm. Offutt, Jr.

ADDRESS 115 S. Harrison St.

WORK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard ~~Street~~ ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Brown

(a) RESIDENCE NO. 921 Shields Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hellen Brown (Address) 92 Shields Place

15 Filed N 7 - 1925, 19 Robert P. harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1924, to Jan. 5, 1925,

that I last saw him alive on Jan. 5, 1925,

and that death occurred, on the date stated above, at 8 P M m.

The CAUSE OF DEATH* was as follows:

Streptococcus Hyglain Stenosis

(duration) yrs. 4 mos 12 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. 26 ds.

18 Where was disease contracted if not at place of death? Present Since birth

Did an operation precede death? yes Date of Dec. 11, 1924

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) A. L. Anderson, M. D.

, 19 (Address) Univ. Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem

DATE OF BURIAL: 1-8 1925

20 UNDERTAKER: Chas Deary

ADDRESS 916 Cathedral

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93799

CERTIFICATE OF DEATH.

3/D 93799

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Johnson

(a) RESIDENCE No. 547 Oxford st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton Johnson

6 DATE OF BIRTH (month, day, and year) 1902 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	22?			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Levi Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 7-1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 19 25

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 19 24, to Jan. 5, 19 25,

that I last saw her alive on Jan. 5, 19 25,

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. S. White M. D.

Jan 5. 19 25 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-8-25
20 UNDERTAKER	ADDRESS 916
David Carton	Conn

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93800

CERTIFICATE OF DEATH.

D 93800

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 574 Greenmeadow St., (WARD) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Parker

(a) RESIDENCE No. 574 Greenmeadow St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Cobbert

11 BIRTHPLACE OF FATHER (city or town) Alabama
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Parker

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Ethel Parker
(Address) 574 Greenmeadow St.

15 Filed JAN 7 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Jan. 6, 1925 (Address) 2812 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	1-8-1925
20 UNDERTAKER Dan'l Easton	ADDRESS 976 Gay

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

D 93801 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Little Pine St. Lot 1. 7-2 101-001 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilly Bromwell

(a) RESIDENCE No. 918 Little Pine St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Bromwell

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 057

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Bromwell
(Address) 918 Little Pine St

15 Filed JAN 7 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rotar Incontinentia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) Dr. T. Hennessy, M. D.
(Coroner.)

Jan. 6, 1925 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 1-8 1925

20 UNDERTAKER David Easton

ADDRESS 976 Ca...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

INK—THIS IS A PERMANENT RECORD. Every in... infor-

AN

Cor.—1-12-23—M&T—100 Bks.

(Tindle)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93802 ✓ D 93802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 90

CITY OF BALTIMORE: (No. 651 Bankes Lane ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Tindle

(a) RESIDENCE No. 651 Bankes Lane ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colo	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Edna Taylor
(Address) 651 Bankes Lane

15 Filed JAN 7 1925 192 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest, autopsy or inquiry.~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

(Signed) W K Gonce, M. D.
(Coroner.)
1-7, 1925 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	1-8-1925
20 UNDERTAKER Dent Fenton	ADDRESS 516 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93803

CERTIFICATE OF DEATH.

D 93803

1-PLACE OF DEATH Municipal Tuberculosis Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Bay View ST., 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Conners

(a) RESIDENCE NO. 719 Ramsay ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred more than 15 yrs exact length of time unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Molder

(b) General nature of industry, business, or establishment in which employed (or employer): 047

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Timothy Conners

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Curtin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records

(Address)

Filed JAN 7 1925, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3rd 1925

17

I HEREBY CERTIFY, That I attended deceased from Aug. 22nd, 1924 to Jan. 3, 1925.

that I last saw h in alive on Jan 3, 1925.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? clin. & Lab findings - autopsy.

(Signed) J. D. White, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jan 8 1925

20 UNDERTAKER: Harry H Kelly ADDRESS: 1531 W Fayette

21

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home

Registered No.....

City of BALTIMORE: (No. Broadway and Fairmount Ave St., 61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Kantola or Kantonen

(a) Residence No. 1236 Addaway Road St., Sparrows Pt. Md Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Olga Kantonen

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tinplate mill worker

(b) General nature of industry, business, or establishment in which employed (or employer) Steel

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Finland

PARENTS.

10-NAME OF FATHER, Paan Kantonen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Finland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Finland

14- (Informant) Olga Kantonen (Address) 1236 Addaway Rd

15- Filed JAN 7 1925 Robert P. Harris Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 4, 1925

17- I HEREBY CERTIFY, That I attended deceased from January 1st 1925 to January 4 1925 that I last saw h. alive on January 4 1925 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis chronic

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John E. Norment M. D

19 (Address) Church Home Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oakland Cemetery — DATE OF BURIAL, Jan 8 1925

20-UNDERTAKER, Harry H Hetzler — ADDRESS 1531 N Lombard St

Burial Permit Clerk

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93805

CERTIFICATE OF DEATH.

+74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 4-1 WARD)

2-FULL NAME Lizzie Smith

(a) RESIDENCE NO. Pulaski md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	#	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Duties

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Samuel Hawkins

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Nelson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Fannie Hawkins
(Address) 340 W. Biddle St.

15 Filed JAN 7 - 1925 Robert P. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1924, to Jan. 6, 1925, that I last saw her alive on Jan 6, 1925, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(Multiple)

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Edwards M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Locust Chapel Cem	Jan 10 1925
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 93806

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Latrobe St., 12-L WARD)

2-FULL NAME Elizabeth Green

(a) RESIDENCE No. 1704 Latrobe St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baptist Green

6 DATE OF BIRTH (month, day, and year) Dec 14 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Baptist Green (Address) 1704 Latrobe St

15 Filed JAN 8 - 1925 ROBERT R. KRAUTER, Registrar. Burial Permit No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1925, to Jan 5, 1925,

that I last saw h[illegible] alive on Jan 5, 1925,

and that death occurred, on the date stated above, at 8:45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Appendicitis

(duration) yrs. 9 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs,

(Signed) Geo. F. Hall, M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	1-8 1925
20 UNDERTAKER George T. C. Gibson	ADDRESS 1736 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93807

CERTIFICATE OF DEATH.

101-001

D 93807

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 538 W. Conway ST., 22-1 WARD)

2-FULL NAME Julia Toy

(a) RESIDENCE NO. 53 E W Conway ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr [illegible]

6 DATE OF BIRTH (month, day, and year) [illegible] 1881

7 AGE: Years 43 | Months 3 | Days 15 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charleston W Va

PARENTS

10 NAME OF FATHER Wm Toy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charleston W Va

12 MAIDEN NAME OF MOTHER Mary Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charleston W Va

14 Informant (Address): Mary 538 W. Conway ad

15 Filed JAN 6 - 1925 ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6/25 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 4/25 .19. to Jan 6/25 .19.
that I last saw he alive on Jan 6/25 .19.
and that death occurred, on the date stated above, at 2.20p m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Chronic Nephritis (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

(Address) 1 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Md.

DATE OF BURIAL: Jan 9 19 25

20 UNDERTAKER: Mrs R. C. Elliott

ADDRESS 1125 Eastland

NAME—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 93808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

27-612 9

D 93808

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Charles FERDINAND Kuhns

(a) Residence No. 264 Oakdale Rd, Roland Park Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 43 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Genevieve McC. Kuhns

6-DATE OF BIRTH (month, day and year) Jan 6-1882.

7-AGE. 43 yrs. 0 mos. 0 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Insurance Business

(b) General nature of industry, business, or establishment in which employed (or employer)..... Insurance Co

(c) Name of employer..... Guardian Life of N.Y.

9-BIRTHPLACE (city or town)... Maryland (State or Country).

PARENTS.

10-NAME OF FATHER, Joseph Kuhns (US)

11-BIRTHPLACE OF FATHER (city or town)... Md. (State or Country).

12-MAIDEN NAME OF MOTHER, Ella Hyland (US)

13-BIRTHPLACE OF MOTHER (city or town)... Md. (State or Country).

14- (Informant) Mrs. Chas. Kuhns

(Address) 204 Oakdale Rd

15- JAN 8 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/6/25

17- I HEREBY CERTIFY, That I attended deceased from Dec 16, 1924, to Jan 6, 1925, that I last saw him alive on Jan 6, 1925, and that death occurred, on the date stated above, at 11:25 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about (Duration) 2 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pericarditis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Elwell Howell M. D.

, 19 (Address) U. M. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. Jan 9, 1925

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

...ING A PERMANENT RECORD. Every item of information ...d.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93809

CERTIFICATE OF DEATH.

90

D 93809

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1716 Duncan St., 17 Ward) Registered No.....

2-FULL NAME..... Mary Schmidt

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No.... 1716 Duncan St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug. 4 1864

7-AGE, 60 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Leopold Schmidt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ger.

12-MAIDEN NAME OF MOTHER. Theresa Riehl

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ger.

14- (Informant) Mrs. Anna Raeszlein

(Address) 1716 Duncan

JAN 8 - 1925 ROBT. J. KRAUSER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1924 to Jan 6 1925

that I last saw her alive on Jan 5 1925

and that death occurred, on the date stated above, at 8 pm.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 1 mos. ds.

Contributory (Secondary) Bronchopneumonia.

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — —

What test confirmed diagnosis? Phy- Exam.

(Signed) H. C. Bladel, M. D.

(Address) 1436 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan 9 1925

20-UNDERTAKER, Jos. F. Merz — ADDRESS 156 N. Luzerne

This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 93810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-60 D 93810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Bartlett ave ST.: 9-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Ludwig

(a) RESIDENCE. NO. 730 Bartlett ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elmer Ludwig

6 DATE OF BIRTH (month, day, and year): June 15th 1857

7 AGE: Years 67 Months 6 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House worker

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Conrad Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lena Gehring

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Elmer Ludwig
(Address) 730 Bartlett ave

15 Filed . 19

JOSEPH R. KRAUTER, Registrar
Burial Permit Clerk.

JUN 9 - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 19 25

17 I HEREBY CERTIFY, That I attended deceased from June 24 . 19 25 to June 6 . 19 25.
that I last saw her alive on June 6 . 19 25.
and that death occurred, on the date stated above, at 8,00 P m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 2 wks. mos. 8 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James W Pinkard, M. D.

6/7, 19 25 (Address) 726 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 9 1925
20 UNDERTAKER	ADDRESS
Johannah Rhodes	1004 Aisquith st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PREPARED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93811

CERTIFICATE OF DEATH.

20-23 D 93811

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2903 Edmondson Ave. St., 20-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna M.Sevier,

(a) Residence No. 2903 Edmondson Ave. St.,..... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced ~~HUSBAND of~~ (or) WIFE of Wm.H.Sevier,

6-DATE OF BIRTH (month, day and year) 1865

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER, Joseph Foller,

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER, Bridget Reddinger,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-
(Informant) Wm.H.Sevier,
(Address) 2903 Edmondson Ave.

15-
Filed JAN 8 - 1925
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) JAN 6 - 1925

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 19 24 to Jan 6 19 25

that I last saw h[illegible] alive on Jan 6 19 25

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis.

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia.

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ND Date of

Was there an autopsy? ND

What test confirmed diagnosis?

(Signed) Wm Mitchell, M. D.

JAN 9 - 1925 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL JAN 9 - 1925, 19....

20-UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

Burial Permit Issued

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93812

CERTIFICATE OF DEATH.

101-001 D 93812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 597 Baker ST., 5-2 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Alonzo Webb.

(a) RESIDENCE NO. 1313 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nina Webb.

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alonza Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alonza Webb.
(Address) 130 Pierce St.

15 Filed 1925 Burial Permit No. Register

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

1925 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 8th 1925

20 UNDERTAKER Joseph A Faul ADDRESS 2119 E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93813

CERTIFICATE OF DEATH.

D 93813
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 Calverton Heights ST., 1 or 5 WARD)

2-FULL NAME Edward James Fahey

(a) RESIDENCE No. 2416 Calverton Heights ST. 5 or WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of: Florence Fahey

6 DATE OF BIRTH (month, day, and year): April 1-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Supt.
(b) General nature of industry, business, or establishment in which employed (or employer): Block Bricks Co
(c) Name of employer: Alt Laute Georgie

9 BIRTHPLACE (city or town)
(State or country): Balto Md

PARENTS

10 NAME OF FATHER: Mark Fahey
11 BIRTHPLACE OF FATHER (city or town)
(State or country): Ireland
12 MAIDEN NAME OF MOTHER: ? Farrell
13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Maryland

14 Informant: Florence Fahey
(Address) 2416 Calverton Heights St

15 Filed JAN 8 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1925 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1925, to Jan 6 1925,
that I last saw him alive on Jan 5 1925
and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
(High Blood Pressure)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage of Brain
(duration) one yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Gradual Increase
(Signed) Thos. F. Phillips, M. D.
. 19 (Address) 2300 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Jan 9th 1925

20 UNDERTAKER: Wm Cook — ADDRESS: 5024 Nor 18

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93814

CERTIFICATE OF DEATH.

161 D 93814

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Cumberland ST. 15-13 WARD)

2-FULL NAME Helen Anna Davidson

(a) RESIDENCE NO. 617 Cumberland ST., ... WARD .....
(Usual place of abode) 4 Hrs.
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5/25

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. ....min.
			4 Hours	

8 OCCUPATION OF DECEASED

(a)-Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) 617 Cumb St
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo Davidson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lula Imhoff

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Lula Davidson
(Address) 617 Cumberland St

15 Filed ..... 19 ..... RUELL A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 7th 1926

17 I HEREBY CERTIFY, That I attended deceased from Jany 5th 1926, to Jany 7th 1926, that I last saw her alive on Jany 7th 1926, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Concussion, due to injuries in auto

10 Days (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Evidence

(Signed) Ed Smith, M. D.

1/7, 1926 (Address) 1605 N. Monroe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Jan. 7 1926
20 UNDERTAKER	ADDRESS
Wm Cook	5 & E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Cor.—1-12-25—M&T—100 Bks.

93815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 N. Bruce ST., 16-7 WARD)

REGISTERED NO. 129 D 93815

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bell

(a) RESIDENCE NO. 806 N. Bruce St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Bell

6 DATE OF BIRTH (month, day, and year) about 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of Industry, business, or establishment in which employed (or employer) general
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Walter Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. DC

12 MAIDEN NAME OF MOTHER Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lucy Bell
(Address) 526 N. Bruce St

15 Filed JAN 8 1925, 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Inter. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Jan. 7, 1925 (Address) 2 Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Jan 8. 1925

20 UNDERTAKER Adolphus Hasted. — ADDRESS 15 Mansion Ave. Catonsville. Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93816

CERTIFICATE OF DEATH.

101-001 D 93816

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 21-3 WARD

2-FULL NAME Perry Walker

(a) RESIDENCE NO. 535 W. Cross ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) S Carolina (State or country)

PARENTS

10 NAME OF FATHER Wm Walker

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed JAN 8 - 1925 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6 1925

17

I HEREBY CERTIFY, That I attended deceased from 12-29, 1924 to 1-6, 1925; that I last saw him alive on 1-6, 1925; and that death occurred, on the date stated above, at 4:00 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude S. Dunn, M. D.

1-7, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hansboro N C	1/8/26
20 UNDERTAKER	ADDRESS
R L Gropp	1405 McElderry

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

D 93817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

D 93817

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 102 E.Montgomery ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A.Woodcock

(a) RESIDENCE NO. 102 E.Montgomery ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J.Woodcock

6 DATE OF BIRTH (month, day, and year) April 4 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Warren

(State or country) Balto.Co. Md.

PARENTS

10 NAME OF FATHER Gilson C.Tracey

11 BIRTHPLACE OF FATHER (city or town) Warren

(State or country) Balto.Co. Md.

12 MAIDEN NAME OF MOTHER Jane Wilson

13 BIRTHPLACE OF MOTHER (city or town) Warren

(State or country) Balto.Co. Md.

14 Informant William J.Woodcock

(Address) 102 E.Montgomery St.

15 Filed JAN 8 - 1925 ROBERT B. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.5 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1925 to Jan 5, 1925

that I last saw h alive on Jan 5, 1925

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H.B.K Campbell, M. D.

Jan 7, 1925 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 6 1925
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

93818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93818

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 W Barney ST., 23-2 WARD)

2-FULL NAME Emeline Zeller

(a) RESIDENCE NO. 17 W Barney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G Zeller

6 DATE OF BIRTH (month, day, and year) Feb 9 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Scherchelz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Heverly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mr John G Zeller 17 W Barney

15 Filed JAN 8 - 1925 19.. BUREAU OF VITAL STATISTICS Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924 to Jan 7, 1925

that I last saw h alive on Jan 6 1925

and that death occurred, on the date stated above, at 3 1/2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell, M. D.

Jan 7, 1925 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 10 1925

20 UNDERTAKER John F Denny ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93819

CERTIFICATE OF DEATH.

31

D 93819

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3516 Park Heights Ave 153 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Bertha M Kirby

(a) Residence No. 3516 Park Heights Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John L Kirby

6-DATE OF BIRTH (month, day and year) Aug 22 1888

7-AGE 36 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Walter A Dowling

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kent Co Maryland

12-MAIDEN NAME OF MOTHER Margaret A Stone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mr Walter A Dowling

(Address) 3516 Park Heights Ave

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6 1925

17- I HEREBY CERTIFY, That I attended deceased from May 14th 1924 to Jan 5th 1925, that I last saw her alive on Jan 5th 1925, and that death occurred, on the date stated above, at 11 P m

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs
Pulmonary Hemorrhage

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Carrick M. D.

, 19 (Address) 412 N Calhoun St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Paul's Cemetery Mr Rockhill Via Tollhouse Frisco — DATE OF BURIAL. Jan 9. 1925

20-UNDERTAKER. John H Denny — ADDRESS 715 Light St

JAN 8 1925 Burial Permit Given

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93820

90

CERTIFICATE OF DEATH.

D 93820

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 W. Barre ST. 22-1 WARD)

2-FULL NAME John A Jones,

(a) RESIDENCE NO. 526 W Barre ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah R. Jones

6 DATE OF BIRTH (month, day, and year) Oct 23 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman of 126

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

(c) Name of employer Hayward Bartlett Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER William C. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Keck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sarah R. Jones (Wife)

(Address) 526 W. Barre St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1920, to Jan. 6, 1925,

that I last saw him alive on Jan. 6, 1925,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dalrett M. D.

Jan 6, 1925 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Jan 8 1925
20 UNDERTAKER	ADDRESS
Jno H. Denny	715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/13

D 93821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Carroll ST. 25-7 WARD.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Allen

(a) RESIDENCE. No. 424 Carroll ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 6 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ethel Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Joseph Allen 424 Carroll St

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1925, to Jan 6, 1925

that I last saw h alive on Jan 6 1925

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell M. D.

19 25 (Address) 1644 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 8 1925
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Burial Permit [illegible]

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93822

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 1204 E. Federal St., 9-6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Albert K. Fischer

(a) Residence No... 1204 E. Federal St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 18-1835

7-AGE. 89 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)..... Piano Factory

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country)..... Germany

PARENTS.

10-NAME OF FATHER, Gottlieb Fischer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country)..... Germany

12-MAIDEN NAME OF MOTHER, Ann Brown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country)..... Germany

14-

(Informant) Adolf K. Fischer

(Address) 1128 Eutaw Place

15-Filed JAN 8 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7th 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 14th 1924 to Jan 5th 1925

that I last saw h. alive on Jan 5th 1925

and that death occurred, on the date stated above, at 4.00 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

Cause say 3 months.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Stone M. D.

(Address) 507 E. Eager St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Jan 10. 1925
20-UNDERTAKER.	ADDRESS.
George Lehmat	1201 Park Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEE 1 Y

K S • A

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 S Addison St. 18-3 Ward)

Registered No. 101-001 D 93823

2-FULL NAME Nettie F Brooks

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 114 S. Addison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 27 1909

7-AGE, 15 yrs. 10 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesgirl

(b) General nature of industry, business, or establishment in which employed (or employer) Lee Lt Store

(c) Name of employer The Leader

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Birch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary F. Craven

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balty Md

14- (Informant) Mary F. Brooks

(Address) 114 S Addison St

15- Filed, JUN 8 - 1925 Burial Permit Issued. Robert R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1925 to Jan 7 1925

that I last saw h alive on Jan 7 1925

and that death occurred, on the date stated above, at 8.50a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) 12 hrs

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

1 7, 1925 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan. 10, 1925

20-UNDERTAKER: George T. Schwab — ADDRESS: 1101 Fulton Ave.

In plain terms, so that it may be properly classified. Instructions on back of certificates.

Entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH Exact statement of OCCUPATION is very important. See

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93824

CERTIFICATE OF DEATH.

101-001 D 93824

1-PLACE OF DEATH 1721

CITY OF BALTIMORE: (No. ~~1321~~ McCubbin St ST., 6-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Nichols (nee Barnett)

(a) RESIDENCE NO 1721 ~~1321~~ McCubbin St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Nichols

6 DATE OF BIRTH (month, day, and year) Dec 25/1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41	0	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family
(c) Name of employer John Geblein

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Solomon Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River Md

12 MAIDEN NAME OF MOTHER Mary Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md

14 Informant Edna Nichols (daughter)
(Address) 1721 ~~1321~~ McCubbin St

15 Filed JAN 8 - 1925, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6th 25

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably (lobar) pneumonia

Cardiac Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exposure to storm Jan2nd (duration) yrs. mos. ds.

(Signed) J. C. Wollen (Coroner.) M. D.

Jan 7-25, 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Jan | DATE OF BURIAL 11th 192 5

20 UNDERTAKER Milton Davis | ADDRESS 315 N Eden St

Spec.—1-10-21—M&T—1500 Blks.

93825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93825

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll Franklin Harris

(a) RESIDENCE NO. ..... ST., ... WARD Lilian, Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	22 10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Carrol R. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lydia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Carroll R. Harris
(Address) Lilian Va.

15 Filed JAN 8 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 1925

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1925, to January 7, 1925;
that I last saw him alive on January 7, 1925;
and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Appendiceal abscess

(duration) ... yrs. mos ... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 7-1925

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Anthony V. Bruhwers M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lilian Va. Roseland Cemetery

DATE OF BURIAL: Jan 10 1925

20 UNDERTAKER: Harry H Watzka

ADDRESS: 1531 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93826

D 93826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 21-3774-001

City of BALTIMORE: (No. 514 W. Hamburg St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Summers

(a) Residence No. 514 W. Hamburg St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: William Summers

6-DATE OF BIRTH (month, day and year): July 9th 1848

7-AGE: 76 yrs. 5 mos. 28 ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Henry Higdon

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary J Legg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-
(Informant): Geo Summers
(Address): 514 W. Hamburg st

15-
Filed ... 192... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 7. 1925

17- I HEREBY CERTIFY, That I attended deceased from ... 19 25 to Jan 7 19 25
that I last saw her alive on Jan 6- 19 25
and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Arterio Sclerosis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage
(Duration) yrs. mos. 6- ds.

18-Where was disease contracted if not at place of death? -
Did an operation precede death? N Date of -
Was there an autopsy? No
What test confirmed diagnosis? P.E.

(Signed) Jolen S. Bishop M. D
19 (Address) 980 N. Calvert St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Jan 10th 192 5

20-UNDERTAKER: E Schloman & Son — ADDRESS: 1034 Hanover st.

JAN 8 - 1925

Burial Permit Clerk.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—4000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93827 — 14 — D 93827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1806 E. Biddle ST.; 8-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Allen

(Residence in Baltimore: No. 1806 E. Biddle St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: Feb. (Month) 21 (Day) 1867 (Year)

7-AGE: 57 yrs. 10 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Hart

(Address) 1806 E. Biddle

15- JAN 8 - 1925 ROBERT R. KRAUTER, Filed ....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1-7-, 1925 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/15 1924, to 1/7 1925, that I saw h[er] alive on 1-7 1925, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(Duration) yrs. 6 mos. ds.

(Signed) David Miller M. D.

1-7, 1925 (Address) 1500 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan. 9, 1925

20-UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93828

CERTIFICATE OF DEATH.

100-001

D 93828

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Joseph's Hosp. St., 9-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Milholland

(a) Residence No. St. Joseph's Hosp St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ———

6-DATE OF BIRTH (month, day and year): ———

7-AGE: 85 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: Arthur Milholland

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Ellen Gallagher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): H.W. Mears & Son's Record

(Address): 805 N. Calvert Street

15- Filed: JAN 8 - 1925 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/6/25

17- I HEREBY CERTIFY, That I attended deceased from 2/14/21 19 to 1/6/25 19

that I last saw her alive on 1/6/25 19

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Myocard. Insuff.

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Senility - Colon

Bronchitis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Evidence

(Signed) Geo B Lybert M. D

, 19 (Address) 6 Wash. Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 1/9, 19 25

20-UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93829

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Asks ST., 17-2 WARD)

2-FULL NAME Baby Cradle

(a) RESIDENCE No. 1067 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

161-001 D 93829

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Bl.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 12/30/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ghd

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Cradle

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Gertrude Herrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) (3) JOHNS

Filed JAN 8 - 1925 19 HILLEL R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1924

17

I HEREBY CERTIFY, That I attended deceased from 12/30, 1924, to 12/30, 1924,

that I last saw him alive on 12/30, 1924,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Stone, M. D.

, 19 (Address) 2. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL JAN 9 19

20 UNDERTAKER Commissioner Health

ADDRESS

per Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

44

Spec.—1-10-21—M&T—1500 Bks.

D 93830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 – 8th ST., 25 WARD)

Mercy Hosp 3 REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Murray

(a) RESIDENCE No. 1136 – 8th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Murray

6 DATE OF BIRTH (month, day, and year) Oct 5 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Bro RR

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank Pullen

(Address) 1136 8th St

15 FILED JAN 8 - 1925 ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 6 1925

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1923, to Jany 6, 1925, that I last saw him alive on Jany 5, 1925, and that death occurred, on the date stated above, at 6-30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) same

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo Schleppler, M. D.

Jany 7 1925 (Address) 2320 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 9 1925
20 UNDERTAKER	ADDRESS
Knell & Sons	1729 W Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93831

CERTIFICATE OF DEATH.

D 93831

1-PLACE OF DEATH — Registered No. 1-49

City of BALTIMORE: (No. 706 S. Robinson St., 1 Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leonard Baumer

(a) Residence No. 706 S. Robinson St., 1 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary Baumer

6-DATE OF BIRTH (month, day and year) Oct 7th 1846

7-AGE. 78 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.
10-NAME OF FATHER. Dont Know
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany
12-MAIDEN NAME OF MOTHER. Dont Know
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Herman H. Baumer
(Address) 2405 Fleet St.

15- Filed JAN 8 - 1925 19 ROBERT R. KRAMES Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 7 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1924 to Jan 7 1925 that I last saw h. alive on Jan 6 1925 and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:
Carcinoma Inguinal Gland

(Duration) 9 Weeks

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Inguinal Gland

(Signed) Hamil L. Linthicum M. D

19 2 (Address) 332 S Paca

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	Jan 9th 1925
20-UNDERTAKER,	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93832

CERTIFICATE OF DEATH.

17 D 93832

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1646 E Fayette ST., 61 WARD)

2-FULL NAME William Fletcher Penty M.D.

(a) RESIDENCE No. 1646 E Fayette ST., WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Trisler Penty

6 DATE OF BIRTH (month, day, and year) Feb. 18 — 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	70	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 669

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer Internal Revenue Dept Baltimore City

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER William Fletcher Penty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rachel Taylor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Baltimore Co. Md

14 Informant Miss Linda J. Penty
(Address) 1646 E Fayette St

15 Filed JAN 8 - 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 25

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1924, to Jan 7, 1925, that I last saw him alive on Jan 6, 1925, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Chronic Valvular heart disease
Angina (duration) 2 yrs. 6 mos. — da.

CONTRIBUTORY (Secondary) Age and Valvular heart disease (duration) yrs. 3 mos. — da.

18 Where was disease contracted if not at place of death? At home of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) William J. Cappage, M. D.

1/7, 1925 (Address) 2305 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Jan. 9th 1925

20 UNDERTAKER L. E. Hughes — ADDRESS 422 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93833

CERTIFICATE OF DEATH.

179 D 93833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital 166 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Hood

(a) RESIDENCE No. 1132 Stockton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/6/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carolina

12 MAIDEN NAME OF MOTHER Clara Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward Hood (Address) 1132 Stockton St

15 Filed JAN 8 - 1925 192 ROBERT B. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 192 5

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Ac Pneumo.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) 1 yrs. mos. ds.

(Signed) J. C. Clark, M. D.
(Coroner.)

192 (Address) 1378 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W.M. Auburn — DATE OF BURIAL: Jan. 9 1925

20 UNDERTAKER: V. A. Brooks — ADDRESS: 1463 W. Coy St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 93834

CERTIFICATE OF DEATH.

24-001

B 93834

1-PLACE OF DEATH Gundry Sanitarium Asbury REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Frederick Road ST.; 28-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Dora C. Nicoll

(Residence in Baltimore: No. Gundry Sanatarium ST.; none)

58 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 22, 1863
(Month) (Day) (Year)

7-AGE, 61 yrs. 10 mos. ..... da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Minden, Hanover, Germany

PARENTS.

10-NAME OF FATHER, Henry Freimann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lizette Freimann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gundry Sanatarium

(Address) Frederick Road

15- Filed JAN 8 1925, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6, 1925
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 31 1922, to Jan 6 1925, that I saw h.. alive on Jan 6th 1925, and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) 2 yrs. 4 mos. ..... da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 12 da.

(Signed) Alfred J. Gundry M. D.

....., 191... (Address) Athol Cockeysville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 5 mos. ..... da. In the State 58 yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? Baltimore City

Former or usual residence ..... " "

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan. 10, 1925

20-UNDERTAKER Henry W. Dears & Son

ADDRESS 808 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93835 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93835

CERTIFICATE OF DEATH.

1-4 10

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3034 Elliott St. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mathew H. Adler.

(a) Residence No. 3034 Elliott St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Dec. 26-1923

7-AGE: 1 yrs. 0 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Henry J. Adler

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Julia Gruthoarska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14- (Informant): Julia Adler.
(Address): 3034 Elliott St.

15- Filed 192 Robert F. Harrison, Deputy Clerk Registrar.

JAN 8 - 1925

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 7-1925

17- I HEREBY CERTIFY, That I attended deceased from January 6, 1925 to January 7, 1925 that I last saw him alive on January 7, 1925 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Laryngeal Diphtheria

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) B. Bronowlar, M. D.

1-7-, 1925 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart. DATE OF BURIAL, Jan. 8th, 1925

20-UNDERTAKER: Lilly & Zeiler. ADDRESS: 403 S. Wolfe St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-3 101 001

D 93836

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2622 E. Baltimore ST., 6 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresia Hannemann

(a) RESIDENCE No. 2622 E Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Hannemann

6 DATE OF BIRTH (month, day, and year) Jan 2 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	68	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Herman Luecking

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fernadina Stiebler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Burnadine Hannemann
(Address) 2622 E Balto St

15 Filed JAN 8-1925, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1926

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Jany 5, 1925, that I last saw her alive on Jany 5, 1926, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia +
Acute Nephritis

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. J. Powers, M. D.

19 (Address) 921 N Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 1-7-1925

20 UNDERTAKER J. J. Moran

ADDRESS 2622 E. Balto St.

THIS IS A PERMANENT RECORD. Every item must be filled in with PENCIL, WITH UNFADING INK—THIS is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93837

HEALTH DEPARTMENT—CITY OF BALTIMORE

188 D 93837

CERTIFICATE OF DEATH

1-PLACE OF DEATH Claremont Station / Union Stock Yards 90-6 REGISTERED NO. .....

CITY OF BALTIMORE, (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Joseph Mikatick

(a) RESIDENCE No 2116 Eagle — ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	37	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Phillip Adelstein
(Address) 2116 Eagle St Johns

15 Filed Dec 8 1925 Robert P. Garrison, Registrar
[illegible], Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage, Stomach —

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Crushed between Car Wheels (Accident) B & O R.R. mos. ds.

(Signed) Thos. B. Norton Unknown, M. D.
(Coroner)

Jan 3rd, 1925 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 1925

20 UNDERTAKER [illegible] Commissioner of Health,

JAN 8 1925

Per. Wm. E. WOODALL.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93838

CERTIFICATE OF DEATH.

90 D 93838

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S. Belnord av ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teofila Reinert

(a) RESIDENCE NO. 626 S. Belnord ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marcel Reinert

6 DATE OF BIRTH (month, day, and year): October 5 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home. no work.

(b) General nature of industry, business, or establishment in which employed (or employer): (All)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Jacob Klein.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Marie Zielinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Neighbor and son-in-law. (Address) 626 S. Belnord ave

15 Filed JAN 8 - 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 7 1925

17 I HEREBY CERTIFY, That I attended deceased from January 4. 1925. to January 7. 1925. that I last saw her alive on January 7. 1925. and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

myocarditis - acute dilatation of heart.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) acute Bronchitis - complicating (duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) E. A. Kolowski. M. D.

1925 (Address) 421 S. Ellwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. Cem. DATE OF BURIAL: Jan. 10 - 1925

20 UNDERTAKER: W. F. Sadowski. ADDRESS: 705 S. Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] may be made TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Kozlowska)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93839

D 93839

CERTIFICATE OF DEATH.

REGISTERED NO. 1-3 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 823 S. Milton Ave (Ward) 1-3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislawa Kozlowska

(a) RESIDENCE NO. 823 S Milton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23/23.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	15	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work: Child. (old)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Kozlowski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Krause.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Frank Kozlowski 823 S. Milton Ave

15 Filed N 8 - 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8. 1925.

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1925, to Jan 7, 1925, that I last saw h[illegible] alive on Jan 7, 1925 and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. ca mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Jamurzeski, M. D.

1/8, 1925 (Address) Fairfax

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Jan. 9" 1925.

20 UNDERTAKER: M J Jadowski ADDRESS: 905 S Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93840

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH West Balto Gaul Hospital 7-3 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lichtenstadt

(a) RESIDENCE No. 656 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lichtenstadt

6 DATE OF BIRTH (month, day, and year): June 26/1853

7 AGE — Years: 71 — Months: 6 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Rochester Kent Co England

PARENTS

10 NAME OF FATHER: Simon Lyon

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rebecca Lyon Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): John Lichtenstein 656 W Franklin

15 Filed 1925 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 8th 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1924, to Jany 8th, 1925, that I last saw her alive on Jany 8th, 1925, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Heart dilation (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustav Stadman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew — DATE OF BURIAL: Jany 8th 1925

20 UNDERTAKER: David Sondheim — ADDRESS: 414 N Mo Royal

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should be careful. AGE should be carefully supplied. AGE should be stated TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Spiro)

D 93841

CERTIFICATE OF DEATH.

135

D 93841

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hosp. St. 3-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Spiro

(a) RESIDENCE No. 1011 E. Lombard St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore St.

15 Filed ....., 19..... Robert P. Harrison, Registrar

8-1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17

I HEREBY CERTIFY, That I attended deceased from 12/10/24 19..... to 1/8 .19 25.

that I last saw h. alive on 1/8 .19 25.

and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

one day

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1/1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/29/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Philip Jacobson, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem. DATE OF BURIAL Jan 8 1925

29 UNDERTAKER Jack Lewis ADDRESS 1439 E. Balt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93842

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 823 Eastern ave, 3-3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francisco Gomez

(a) Residence No. 823 Eastern ave Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, Widower or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 20 1847

7-AGE. 78 yrs. mns. ds. If LESS than 1 day, hrs. mr. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14-

(Informant) Charles Gomez

(Address) 823 Eastern ave

15-

Filed JAN 1925 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 6 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1924 to Jan 5 1925

that I last saw him alive on Jan 5 1925

and that death occurred, on the date stated above, at 1 15 4 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) 4 yrs. mns. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. K. Valentine M. D

Jan 27, 1925 (Address) 1452 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincent

DATE OF BURIAL. Jan 9, 1925

20-UNDERTAKER. Wendell Oppelsson

ADDRESS 378 Mun

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

D 93843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 224 Albemarle St., 3-1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Depentimo

(a) Residence No. 224 Albemarle St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 1 1859

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Horse Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Daniel Peters

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Dominca Depentimo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14-

(Informant) Mary Depentimo

(Address) 224 Albemarle

15-

Filed JAN 8 - 1925 19

Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 2-25

17- I HEREBY CERTIFY, That I attended deceased from January 4 1925 to Jan 7 1925

that I last saw h[illegible] alive on Jan 7 1925

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

2

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M.D.

Jan 8 1925 (Address) 14 So Bond St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. January 9 1925

20-UNDERTAKER, Wendell Roepfel & Son — ADDRESS 378 Lemmon

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 93844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93844

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 E 35th St.; 9-1 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Frada B. Curran

(Residence in Baltimore: No. Same 609 E. 35th St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 7

4-COLOR OR RACE, W

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, Dec. ..... (Month) ..... (Day) 1878 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Jos. Larkins

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pat Curran

(Address) 609 E 35th St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

8-1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7 (Month) (Day) 1925 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 7 1925, that I saw h~~e~~r alive on Dec 4 1925, and that death occurred, on the date stated above, at 1700 m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

..... (Duration) ..... yrs. ..... mos. 1 hr. ..... ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

..... (Duration) 8 yrs. ..... mos. ..... ds.

(Signed) Henry B. Curran M. D.

....., 1925 (Address) 1 Upland Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Govans Cem't — DATE OF BURIAL, Dec 9, 1925

20-UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Queen

(a) Residence No. Poor House & Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, ~~Married, Widowed, or Divorced~~ (Write the word) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1850

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, James Queen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Sister Florence

(Address) Little Sisters of the Poor

15- Filed 19. Robert P. Harrison, Registrar.

NOV - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jany 4 1925

17- I HEREBY CERTIFY, That I attended deceased from No record 19..., to ..., 19...,

that I last saw h. alive on Jany 4, 19 25, and that death occurred, on the date stated above, at 3.C m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Uremia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral DATE OF BURIAL, Jan 9, 1925

20-UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmount Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93846

CERTIFICATE OF DEATH.

25-5

1-PLACE OF DEATH

City of BALTIMORE: (No. 1324 W. Baltimore Ave St. ..... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Nellie H. Ryan

(a) Residence No. 1324 W. Baltimore Ave St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank E Ryan Jr.

6-DATE OF BIRTH (month, day and year) Jan 23 1890

7-AGE. 34 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House work

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Philadelphia Pa

PARENTS.

10-NAME OF FATHER. William J. Scheirs

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Catherine Gregg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Oregon

14- (Informant) Mr. Frank E. Ryan Jr.

(Address) 1324 W Baltimore Ave.

15- Filed 1925 Robert P. Harrison, 192.... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 6 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 19 24 to Jany 6 19 25

that I last saw h[illegible] alive on Jany 4 19 25

and that death occurred, on the date stated above, at 2-25A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Geo. F. McKeffer M. D.

Jan 7, 1925 (Address) 1820 Bolton Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 9, 1925
20-UNDERTAKER. John F. Cowan & Son, per G. F. Cowan	ADDRESS 901 Hollins St.

Should be accurately supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93847

CERTIFICATE OF DEATH.

D 93847

1-PLACE OF DEATH

City of BALTIMORE: (No. 2315 Eastern av St., 1 Ward)

Registered No. 125

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Samuel Chiveral

(a) Residence No. 2315 Eastern av St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 28-1889

7-AGE. 35 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Draftsman

(b) General nature of Industry, business, or establishment in which employed (or employer) Machine Dept

(c) Name of employer Brown Dull & Cayl

9-BIRTHPLACE (city or town) (State or Country), Fredericksburg Va

PARENTS.

10-NAME OF FATHER, James Thomas Chiveral

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Fredericksburg Va

12-MAIDEN NAME OF MOTHER, Hattie F Jenkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Fredericksburg Va

14- (Informant) Mrs Hattie E Chiveral

(Address) 2315 Eastern

15-

Filed ..... 1925 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 7 /25

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923 to Jan 7, 1925

that I last saw him alive on Jan 7, 1925,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted None

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C J Fox M. D.

1/8, 1925 (Address) 270 Eastern av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Jan 10, 1925
20-UNDERTAKER.	**ADDRESS**
Peter Nicolaus 2060	E. Eastern Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 E Monument St., 10-7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna K Persohn

(a) Residence No. 1212 E Monument St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frank A Persohn

6-DATE OF BIRTH (month, day and year) Nov 18th 1866

7-AGE, 58 yrs. 1 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pittsburg Pa

PARENTS.

10-NAME OF FATHER, John Schaler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Andrews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Frank A Persohn

(Address) 1212 E Monument St

15-Filed JAN 8 1925

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7th 1925

17- I HEREBY CERTIFY, That I attended deceased from June 10 1924 to Jan 6 1925

that I last saw h[illegible] alive on Jan 6 1925

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Ch Tuberculosis (Pulmonary)

(Duration) 2/ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Stromberg, M. D.

1/8, 1925 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cem — DATE OF BURIAL, Jan 10th, 1925

20-UNDERTAKER, George Schilling & Son — ADDRESS 1266 Monument St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

17245

HEALTH DEPARTMENT—CITY OF BALTIMORE

17D 93849

CERTIFICATE OF DEATH.

1245D 93849

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Miller

(a) RESIDENCE NO. Jonesboro Tenn ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	-	.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER James Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Martha Shelby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 8 1925 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924 to Jan 8, 1925, that I last saw h[illegible]live on Jan 8, 1925, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of Jan. 7, 25

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) W. P. Harrison M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jonesboro Wash Co. Tenn	1/9 1925
20 UNDERTAKER	ADDRESS
Chas P. Ward & Son	118 W. Royal St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93850

CERTIFICATE OF DEATH.

D 93850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. Baltimore WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Charles Stoffle

(a) RESIDENCE NO. Manchester Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Sebastian Stoffle

6 DATE OF BIRTH (month, day, and year) Jan 1st 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Farmer)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Manchester (State or country) Md.

PARENTS

10 NAME OF FATHER Sebastian Stoffle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wirt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchester

14 Informant Mrs. Chas. Stoffle (Address) Manchester

15 Filed JAN 8 - 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 22. 1924. to Jan 8 1925.

that I last saw him alive on Jan 8 1925

and that death occurred, on the date stated above, at 1:35 P m.

The CAUSE OF DEATH* was as follows:

Left indirect inguinal Hernia.

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of Dec 23-24

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E M Foose M. D.

, 19 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md

DATE OF BURIAL Jan 8 1925

20 UNDERTAKER W M Routson

ADDRESS 2235 N Mda.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Lyman

D 93851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93851

CERTIFICATE OF DEATH.

12-529

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Home For Incurables, Guilford Ave., St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise E. Lyman,

(a) Residence No. Home For Incurables, St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry E. Lyman

6-DATE OF BIRTH (month, day and year) April 4, 1848

7-AGE, 62 9 2 yrs. mos. ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country).

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country).

14- (Informant) Henry Lyman
(Address) 1551 E. Baltimore St.

15- Filed JAN 8 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6th 1925

I HEREBY CERTIFY, That I attended deceased from November 15 1924 to Jany 6 1925

that I last saw h[er] alive on Jany 6 1925

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arter. Nephritis - Arterio Sclerosis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Admission to Home for Incurables

Did an operation precede death? N.O. Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Laboratory tests Physical examination

(Signed) Robt P. Harrison, M. D.

, 19 (Address) Latrobe Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, ..., 19...
20-UNDERTAKER Harry D. Wilzbach	ADDRESS

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Cor.—1-12-25—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93852

CERTIFICATE OF DEATH.

22-2 90 D 93852

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 836 Peach Alley. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wallace Miles.(C)

(a) RESIDENCE No. 836 Peach Alley. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Anna Pack.(C)
(Address) 1236 S. Eutaw St.

15 Filed ... 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

THE MORGUE: K Jan 1 1-8 25

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.
Acute cardiac dilatation.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

Jany. 8th. 192 5 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence (Col.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St. DATE OF BURIAL Jan 9 1925

20 UNDERTAKER I. L. Bromwell Son ADDRESS 1081 W Mont

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

D 93853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 28

CITY OF BALTIMORE: (No. 119 W. Montgomery ST. 22-2 90 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brooks

(a) RESIDENCE NO. 119 W. Montgomery ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ike Brooks

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER James Howden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Hester Costen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant. (Address) Sarah Howden 119 W Montgomery St

15 Filed 1925 ROSE P. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7/1925

17

I HEREBY CERTIFY, That I attended deceased from 12/27/, 1924, to 1/7/, 1925,

that I last saw her alive on 1/7/, 1925

and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) D. M. Bigler, M. D.

, 19 (Address) 709 Hearn St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	1/9/1925
20 UNDERTAKER	ADDRESS
Isaiah L Brown & Son	108 Montg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93854

CERTIFICATE OF DEATH.

4-1 129 D 93854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 W. Saratoga St., ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence W. Johnson,

(a) RESIDENCE NO. 707 W. Saratoga St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Johnson.

6 DATE OF BIRTH (month, day, and year) Dec., 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer) For Traveling Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known.

12 MAIDEN NAME OF MOTHER Jane Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Lizzie Johnson,

(Address) 707 W. Saratoga St.

15 Filed. — —, 19 — ROBERT R. KRAUTER, Registrar

JAN 9 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1924, to Jan. 7, 1925,

that I last saw him alive on Jan. 7, 1925,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis of Heart.

(Duration)

Not known. yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.

Not known. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical.

(Signed) Harry F. Brown, M. D.

, 19 (Address) 1501 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE—	DATE OF BURIAL
MAUSOLEUM Laurel Cemetery	Jan 10 1925
20 UNDERTAKER	ADDRESS
Clarence E. Wright	1364 Mary

SHOULD BE FILLED OUT CAREFULLY AND WRITTEN PLAINLY. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93855

CERTIFICATE OF DEATH.

17-238 D 93855

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Brown

(a) Residence No. 1030 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1863

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JAN 9 - 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-7-25

17- I HEREBY CERTIFY, That I attended deceased from 12-14, 1919, to 1-7, 1925, that I last saw him alive on 1-7, 1925, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis C.N.S. Syphilis

Carcinoma of Prostate

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab & Autopsy

(Signed) Claude S. Drace, M. D.

1-7, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL, Jan 9, 1925

20-UNDERTAKER, John H. Toadvine

ADDRESS 192 Eutaw St

In plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Also CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

D 93856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE (No. 22-1 ST., 38 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Jones

(a) RESIDENCE No. 5442 W. Lemmon ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE: Years 33 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Staunton Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Boy View Hospital

15 Filed ..... 19 ..... Registrar
JAN 9 - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 7. 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8. 1924 to Jan 7, 1925
that I last saw him alive on Jan 6 1925
and that death occurred, on the date stated above, at 3.30 A. m.
The CAUSE OF DEATH* was as follows:

General Paralysis (7th Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lues Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. Goldsmith M. D.
1/7/1925 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bet. Unknown — DATE OF BURIAL: Jan 10 1925

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Uxbridge

Burial Permit Clerk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93857

CERTIFICATE OF DEATH.

100-001

D 93857

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 564 St Marys — ST. 17-2 WARD)

2-FULL NAME Lizzie Parker

(a) RESIDENCE. No. 564 St Marys — ST.— WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53 —			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Johns Hall

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Last Name

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Lizzie Brown
(Address) 1333 Argyle Ave

15 Filed JAN 9 - 1925 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6th 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan — 4th, 1925, to Jan 6, 1925, that I last saw h[illegible] alive on Jan 6th, 1925, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Samuel A Bair, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 9 1925
20 UNDERTAKER	ADDRESS
John H Godwin	142 W Hill St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEE 75 CTS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93858

CERTIFICATE OF DEATH.

1001

D 93858

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 E. 30th ST., 9-3 WARD)

2-FULL NAME Charles H Freeman

(a) RESIDENCE NO. 635 E 30 st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie M Freeman

6 DATE OF BIRTH (month, day, and year) JAN 17 1899

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25	11	22	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Telegraph

(b) General nature of industry, business, or establishment in which employed (or employer) Operator

(c) Name of employer Fire Insurance Bureau

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George W Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Julia Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King William Va

14 Informant Mrs Lottie M Freeman

(Address) 635 E 30 st.

15 Filed JAN 9 - 1925, 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1925, to Jan 8, 1925, that I last saw h in alive on Jan 7, 1925, and that death occurred, on the date stated above, at 2 50 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Disease

(duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Did not know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. K. Cooley, M. D.

1-8, 1925 (Address) 428 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wood Lawn	JAN 12 1925
20 UNDERTAKER John F Denny	ADDRESS 715 Lig't St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

93859 55 D
1772

HEALTH DEPARTMENT—CITY OF BALTIMORE D 93859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 5-2-51 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Jackson

(a) RESIDENCE NO. 1316 Orleans St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
8	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JAN 9 - 1925 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6, 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1924 to Jan 6, 1925.

that I last saw her alive on Jan 6, 1925.

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

Myocardial failure

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, secondary

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? ~~yes~~

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury cemetery

DATE OF BURIAL Jan 9 1925

20 UNDERTAKER Edward Bryson

ADDRESS 1631 Orleans St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bka.

D 93860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt. Gen. Hosp. ST., 11-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. E. Merryman

(a) RESIDENCE NO. Owings Mills ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicky Julia Merryman

6 DATE OF BIRTH (month, day, and year) March 14, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer D30
(b) General nature of industry, business, or establishment in which employed (or employer) (Ice Co.)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Merryman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ellis Dietz

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Molly J. Merryman
(Address) Owings Mills Md

15 Filed JAN 9 1925, 192 ROBERT A. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardio - Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pending Stomach Analysis

(duration) yrs. mos. ds.

(Signed) J. J. Heaney M. D.
(Coroner.)

Jan. 8, 1925 (Address) 280 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 10 1925

20 UNDERTAKER Carroll & Md ADDRESS
J. F. Eline Reisterstown Md

TION is very important. See instructions on back of certificate.

at it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

93861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93861

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wyman Park Apts. ST., 13-4 WARD)

2-FULL NAME Mrs. Mary E. Oliver,

(a) RESIDENCE No. Wyman Park Apts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm B. Oliver

6 DATE OF BIRTH (month, day, and year) Sept 27th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles S. Getz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster, Pa.

12 MAIDEN NAME OF MOTHER Sophia Theresa Sommer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Pa.

14 Informant Charles Getz, M. D. (Address) 1111 W. Lanvale St.

15 Filed JAN 9 - 1925 ROBERT B. BRANTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2d 1925 to Jan 7th 1925 that I last saw h alive on Jan. 7th 1925 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris,

(the last attack 6 days)

Chronic Interstitial Nephritis

(duration) 15 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? Mt Balto. Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Physical signs.

(Signed) Charles Getz, M. D.

Jan 7, 1925 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan 10 1925

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 2-2-2 34

CITY OF BALTIMORE; (No. Municipal Tuberculosis Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Junius Slocum

(a) RESIDENCE No. 114 W. Montgomery st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Graham Slocum

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lavinia Cherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1924 to Jan. 6, 1925.

that I last saw him alive on Jan. 6, 1925,

and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the spine

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. F. White M. D.

1-6-25 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

W Baltimore Jan 11 1925

20 UNDERTAKER — ADDRESS

Sam'l H. Chase Sons Madison

IMPORTANT—RECORD EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Time of Death corrected to Monday Jan. 12/25

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93863

D 93863

J. Frederick Campbell asst. Com.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 N. Vincent ST. 16-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Anderson

(a) RESIDENCE No. 1106 N. Vincent ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Anderson

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lackey Wormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Rosa Anderson

(Address) 1106 Vincent

15 Filed JAN 9 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st 1924, to Jan 7th 1925.

that I last saw him alive on Jan 7th 1925.

and that death occurred, on the date stated above, at 10:20 p m.

The CAUSE OF DEATH* was as follows:

Chr. Interst. Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Histology

(Signed) Jas E Bell M. D.

1-13-1925 (Address) 1211 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Jan 12 1925
20 UNDERTAKER	ADDRESS
Sam'l M Chase Son	1400 Mosher

INSTRUCTIONS—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93864 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 N. Ellwood Av ST., 7-3 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva E. Wiegand

(a) RESIDENCE NO. 606 N. Ellwood Av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Late Adam Wiegand

6 DATE OF BIRTH (month, day, and year) July 20/46

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Steven Meisler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Eckels

(Address) 606 N. Edward

15 Filed JAN 9 - 1925 19 ROBERT R. KRAUTER, Registrar

Assist. Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1925

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1925, to Jan 7, 1925, that I last saw h[illegible] alive on Jan 8, 1925, and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Senile Debility

Chronic Bronchitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Pneumonia (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? per Dr. Meyer

What test confirmed diagnosis?

(Signed) Dr. Carl H. Meyer M. D.

, 19 (Address) 5414 Belton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cem.

DATE OF BURIAL 1/10 1925

20 UNDERTAKER Philip Herwig

ADDRESS 2012 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93865

1-PLACE OF DEATH Maryland Gen. Hosp. 13-657 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Madison Ave. St., 2nd WARD)

2-FULL NAME George M. Hay

(a) RESIDENCE NO. 725 Lemmon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Sarah Hay

6 DATE OF BIRTH (month, day, and year) Aug 4, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69 yrs	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Solicitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Geo. M. Hay

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant J. D. Hay (Address) 725 Lemmon St.

15 Filed JAN 9 - 1925 19 AUGUST R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1925

17 I HEREBY CERTIFY, That I attended deceased from 1/7/25, 19..., to 1/8/25, 19...

that I last saw h[illegible] alive on 1/8/25, 19...

and that death occurred, on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Diffuse Nephritis (?)
Diabetes Mellitus (30 yrs)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Thos. A. Tandler M. D.

, 19 (Address) 715 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Jan 10th 1925
20 UNDERTAKER	ADDRESS
J. A. Jones.	124 N. Green St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 93866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93866

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 N. Conway ST.; 22-1 WARD)

2-FULL NAME Mrs. Margaret C. Schafer

(a) RESIDENCE. No. 637 N. Conway ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry R. Schafer

6 DATE OF BIRTH (month, day, and year) April 25th 1825

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	99	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know first name Woeninger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carolyn Schafer
(Address) 637 N. Conway

15 Filed JAN 9 - 1925 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct 27th, 1924, to Jan 7th, 1925, that I last saw her alive on Jan 7th, 1925, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart

Do not Know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carrick M. D.

19 (Address) 412 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Jan 10 1925

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 601 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93867

CERTIFICATE OF DEATH.

188 D 93867

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) Spring Grove Hospital ST., WARD

2-FULL NAME John F. Chubb.

(a) RESIDENCE NO. 794 N. Gross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ice
(c) Name of employer Wade Dept

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Chubb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant (Address) Mary E. Thompson 794 N. Gross St

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Injuries due to Caving in of a ditch. (Accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Lemmon, M. D.
(Coroner.)

Jan 8, 1925 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem	Jan 10 1925
20 UNDERTAKER	ADDRESS
Mrs Mrs J. W. Tenfelt & Son	801 W. Fayette

THION is very important. See instructions on back of certificate.

Burial Permit Issued

Spec.—1-10-21—M&T—1500 Blks.

D 93868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-2 129

D 93868

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3701 Yosemite Ave ST. 15 WARD)

2-FULL NAME John Louis Tyrell

(a) RESIDENCE NO. 3701 Yosemite Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, ~~HUSBAND OF~~ (or WIFE) of Husband of Martha E Tyrell

6 DATE OF BIRTH (month, day, and year) May 2 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	50	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) as in a.

(c) Name of employer Hochschild, Kohn & Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Tyrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Drovey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Martha Tyrell (Address) 3701 Yosemite Ave

15 Filed . 19 ORIG. SIGN'D LEON R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9, 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 . 1925 . to Jan 8 . 1925 .

that I last saw him alive on Jan 7 . 1925 .

and that death occurred, on the date stated above, at 1030 P. m.

The CAUSE OF DEATH* was as follows:

Sept Hemi-plegia, (Paralysis)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chronic Brights Dis't High blood pressure (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E B. Emsor, M. D.

1-8. 1925 (Address) 5106 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Jan 12" 1925

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Calvert St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should know that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13-90

D 93869 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 630 W.North Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ellen Justice

(a) Residence No. 630 W. North Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Justice

6-DATE OF BIRTH (month, day and year): Nov. 1864

7-AGE: 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore

(State or Country): Maryland

PARENTS.

10-NAME OF FATHER: James Dunnigan

11-BIRTHPLACE OF FATHER (city or town):

(State or Country): United States

12-MAIDEN NAME OF MOTHER: Sarah Thomas

13-BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or Country): Maryland

14- (Informant): Mrs. Florence Michael

(Address): 630 W.North Ave.

15- Filed 192 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 8, 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 1925, to Jan 8, 1925, that I last saw h. alive on Jan 8, 1925, and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1-8-. 19 25 (Address) 720 W.North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: Jan 10" 25

20-UNDERTAKER: Joseph B. Cook ADDRESS 1003 W. Baltimore St.

in plain terms, so that it may be properly classified. instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 93870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 WARD)

REGISTERED NO. 1129 D 93870

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caesar Baker

(a) RESIDENCE NO. 1727 Maryland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Westly Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed JAN 9 - 1925 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8 1925

17

I HEREBY CERTIFY, That I attended deceased from 12-20, 1924 to 1-8, 1925

that I last saw him alive on 1-8, 1925

and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Chronic Nephritis; Right Hemiplegia (Hemorrhage?) 4 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Dixon M. D.

1-8, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Jan, 9 1925

20 UNDERTAKER Samuel T. Hensley ADDRESS 1728 Eddy St

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 93871 — 101-001 — Registered No. C 93871

1-PLACE OF DEATH MARY SAPP 18

CITY OF BALTIMORE (No. 104 N. Schroeder St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Sapp

(Residence in Baltimore: No. 104 N. Schroeder St.; 8 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Colored	Married

6-DATE OF BIRTH: May 1, 1917 (Month) (Day) (Year)

7-AGE: 7 yrs. 8 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Columbia South Carolina

PARENTS

10-NAME OF FATHER: Peter Parker

11-BIRTHPLACE OF FATHER (State or country): South Carolina

12-MAIDEN NAME OF MOTHER: Lucy Matthews

13-BIRTHPLACE OF MOTHER (State or country): South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Sapp.

(Address) 104 N. Schroeder St

15- Filed JAN 9 - 1925 19.. ROBERT E. KRAUTZ Registrar

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: ..... (Month) ..... (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191.., to ....., 191.., that I saw h.. alive on ....., 191.., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 12 192[illegible]
UNDERTAKER Samuel L Hensley	ADDRESS 578 W Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

D 93872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93872

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Forest Ave

CITY OF BALTIMORE: (No. Hilsdale Md ST., 28-3 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha T. Eccles

(a) RESIDENCE NO. Hilsdale Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 6 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
~~Female~~	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 12, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Samuel Eccles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Eckel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Rose E Bailey
(Address) Hilsdale, Md

15 Filed JAN 9 1925, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1924, to Jan 9th, 1925, that I last saw h[illegible] alive on Dec 29th, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Trouble.

(duration) 6 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Valvular Heart Trouble,
(duration) — yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo F Evershaw, M. D.
, 19 (Address) Woodlawn Station

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stanton, Delaware

DATE OF BURIAL Jan 10 1925

20 UNDERTAKER Edw Cook & Bro E

ADDRESS [illegible]

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-2 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Agnes Louise Hart

(a) Residence No..... Little Sisters of the Poor St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced~~ (Write the word.)

5a-If ~~married~~, widowed, or ~~divorced~~ (or) WIFE of George Hart

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 78 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER, John Frances

11-BIRTHPLACE OF FATHER (city or town) (State or Country). —

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant)..... Sister Florence

(Address)..... Little Sisters

15- Filed ..... 1925 ....., 192.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 8 1925

17- I HEREBY CERTIFY, That I attended deceased from Norember ....., 19....., to ....., 19.....

that I last saw h. alive on ....., 19.25.,

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Fall. Warner, M. D.

Jan 9, 1925 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, June 10, 1925

20-UNDERTAKER, Wm Cook — ADDRESS 507 E. North Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Hall) 341 Mosher St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93874 D 93874

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 14147

CITY OF BALTIMORE: (No. 341 Mosher ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Hall

(a) RESIDENCE NO. 341 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Horace Hall

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Cassell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mabel Murdock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Horace Hall (Address) 341 Mosher St

15 Filed JAN 9 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8th 1925

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9th 1924, to Jan. 8th 1925, that I last saw h alive on Jan. 6th, 1925, and that death occurred, on the date stated above, at 1500 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Stenosis.

Arthritis.

(duration) Immediate ds.

CONTRIBUTORY (Secondary) Carcinoma of the Stomach (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date March 4, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 845 N. Mon. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Jan 11 1925

20 UNDERTAKER Clarence E. Wright — ADDRESS 1364 W. Lanv

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93875 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 190

City of BALTIMORE: (No. St. Joseph Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Paelzold

(a) Residence No. 1819 E. Pratt St., Ward
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Paelzold

6-DATE OF BIRTH (month, day and year): Oct 20 1854

7-AGE: 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.
10-NAME OF FATHER: Gustav Paelzold
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Dot Known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Charles Baltzell
(Address): 1819 E. Pratt St.

15- Filed JAN 9 - 1925 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 7, 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1925 to Jan. 7, 1925
that I last saw h[illegible] alive on Jan. 7, 1925
and that death occurred, on the date stated above, at 10:55 p.m.
The CAUSE OF DEATH* was as follows:
Cellulitis, Left Foot.
(Duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary): Myocardial Insufficiency
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Findings
(Signed) B. M. Rhodes M. D.
, 19 (Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Hamel — DATE OF BURIAL: Jan. 10, 1925

20-UNDERTAKER: Randall Apple & Son — ADDRESS: 37 S. [illegible]

PRINTED EXACTLY. PHYSICIANS SHOULD READ CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 E. Franklin Ave.) ST. [illegible] WARD 12

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [illegible] Sipple of C.

(a) RESIDENCE No. 2196 E. Franklin Ave ST., Raspeburg WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Sipple

6 DATE OF BIRTH (month, day, and year) Jan. 3rd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Conrad Sipple

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Finkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary C. Sipple (Address) 2196 E. Franklin Ave.

15 Filed [illegible] 19 Robert P. Harrison, Registrar

NOV 9 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1926

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1925, to Jan 8, 1926, that I last saw him alive on Jan 7, 1925, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Edward Benson, M. D.

(Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Lutheran Cem.	Jan 11 '26
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93877

CERTIFICATE OF DEATH.

D 93877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay. View Hospital. 16 ST... WARD) REGISTERED NO. 16-45

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Kahanoi

(a) RESIDENCE No 920 N. Monroland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22 -			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cotton mill
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Hawaii Island

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant ...
(Address) ...

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Hg Clz.

(Duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Ac Nephritis

(Duration) ... yrs. ... mos. 2 ds.

(Signed) G. C. Clark, M. D. (Coroner)

Jan 7/25, 192 (Address) 435 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JAN 9 1925

UNDERTAKER Commissioner of Health.
Per. Wm. E. WOODALL

JAN 9 1925

THE MORGUE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93878

CERTIFICATE OF DEATH.

D 93878

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hosp. (ST.,) 3-3 (WARD) 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Chronister.

(a) RESIDENCE NO. 1415 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frostburg, Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed , 192 Registrar

Robert P. Harrison

JAN 9-1925 0084 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmon. T. B.

(Duration) mos. ds.

CONTRIBUTORY (Secondary) Chronic Ulcer (duration) yrs. mos. 1 ds.

(Signed) Geo C Blades, M. D. (Coroner.)

Jan 7 1925 192 (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health,

ADDRESS JAN 9-1925

Per. Wm. E. McGrath

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93879

CERTIFICATE OF DEATH.

D 93879

1-PLACE OF DEATH CITY OF BALTIMORE (No.) 8 Bay View ST., 7-1 WARD) REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Lute

(a) RESIDENCE NO. 1912 Hon Atlas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE C | 5 Single, Married, Widowed, or Divorced (write the word) Not Known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

Issued Burial Permit Left

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1925.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Broncho Pneumonia (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) G. Scott Lewis M. D. (Coroner.)

Jan 6 192 (Address) 143 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL | DATE OF BURIAL 192

20 UNDERTAKER J. 4 1925 | ADDRESS

Buried Laurel Cemetery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Flauenheim

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93880

CERTIFICATE OF DEATH.

93880

1-PLACE OF DEATH

City of BALTIMORE: (No. 601 W Hamburg St., 21 Ward) 101-3

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John A. Schaffner

(a) Residence No..... 601 W. Hamburg St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Matilda Schaffner.

6-DATE OF BIRTH (month, day and year) Dec 4.

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired 63

(b) General nature of industry, business, or establishment in which employed (or employer) Cigarmt Worker

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Germany
(State or Country),

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town)..... Germany
(State or Country),

14- (Informant) Matilda Schaffner

(Address) 601 N Hamburg St

15- Filed ..... 19.....

Robert F. Harrison
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 9 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1925 to Jan 9, 1925, that I last saw him alive on Jan 8, 1925, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wirley Hoag M. D.

Jan 9. 1925 (Address) 712 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cem. DATE OF BURIAL, 1/12 1925

20-UNDERTAKER, James. Dignan & Son ADDRESS 1000 E Pratt St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

D 93881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93881

CERTIFICATE OF DEATH.

1674-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 N Monroe ST. 16 WARD)

2-FULL NAME John B Grace

(a) RESIDENCE. No. 816 N Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Katherine Grace

6 DATE OF BIRTH (month, day, and year) Aug 13 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk at Bkry
(b) General nature of industry, business, or establishment in which employed (or employer) Schmidts Bakery
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS
10 NAME OF FATHER Wm E. Grace
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Charlotte Bennighof
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Katherine Grace.
(Address) 816 N Monroe St

15 Filed JAN 9 1925, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1924, to Jan 8, 1925, that I last saw h[e] alive on Jan 7, 1925, and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis without edema

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) N. G. Jones, M. D.

1/9, 1925 (Address) 720 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western.	1-10 1925

20 UNDERTAKER Wm Chas A. G. Rohde ADDRESS 600 N Carlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93882

CERTIFICATE OF DEATH.

743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2643 Hampden Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard S. Sutter

(a) RESIDENCE NO. 2643 Hampden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7 - 1886

7 AGE 39 Years 10 Months 30 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs M. Louisville

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Sutter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Millburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E. Sutter Mother

(Address) 2643 Hampden Ave

15 Filed Jan 9, 1925 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1924 to Jan 8, 1925 that I last saw him alive on Jan 8, 1925 and that death occurred, on the date stated above, at 9.16 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

under

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Tongue (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 24

Was there an autopsy? No

What test confirmed diagnosis? Keeley's Sanborn

(Signed) L A Richardson, M. D.

Jan. 9, 1925 (Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan 10 1925
20 UNDERTAKER	ADDRESS
Mary A Gawthrop	2739 Raymond Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should use the International Nomenclature. AGE should be carefully supplied. Exact statement of OCCUPATION is very important, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Senaly)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93883

CERTIFICATE OF DEATH.

101 208 93883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1230 O. Decker Ave ST., 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Senaly

(a) RESIDENCE NO. 1230 O Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Senaly

6 DATE OF BIRTH (month, day, and year) March 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gds

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Senaly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Senaly

(Address) 1230 N Decker Ave

15 Filed JAN 9 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 29, 1924, to Jan 7, 1925,

that I last saw him alive on " 7, 1925

and that death occurred, on the date stated above, at 3p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas Green, M. D.

1/9/1925 (Address) 408 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 11 1925
20 UNDERTAKER	ADDRESS
Frank Enoch Son	1006 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 93884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93884

CERTIFICATE OF DEATH.

25-11 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 112 Filbert St. Curtis Bay. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Houdek.

(a) RESIDENCE NO. 112 Filbert St. Curtis Bay. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---mos.---ds. How long in U. S., if of foreign birth? 20 yrs.---mo.---ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widowed

5a If married, widowed, ~~XXXXXX~~ HUSBAND of ~~XXXXXX~~ Annie Houdek.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	////	////	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mary Sallin.(daughter)
(Address) 14 Cherry St. Curtis Bay.

15 Filed APR 9 1925 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

Jany 9th. 1925 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Jan 10 1925
20 UNDERTAKER Frank E. Woodson	ADDRESS 1906 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 93885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE. (No.) 816 N. Madeira St., 7 Ward) Registered No. D 93885

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Klein

(a) Residence No. 816 N. Madeira St. Ward

(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND or (or) WIFE of Frank X Klein

6-DATE OF BIRTH (month, day and year) [illegible] Known

7-AGE 67 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) (State or Country) [illegible]

10-NAME OF FATHER [illegible]

11-BIRTHPLACE OF FATHER (City or Town) (State or Country) [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10, 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1925 to Jan 9 1925

that I last saw h[illegible] alive on Jan 9, 1925

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

Duration yrs. mos.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration)

18-Where was disease contracted? (If not at place of death)

Did an operation precede death? Date

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Murmurs

Signature

Address

Date signed

Physician.

Exact statement of OCCUPATION is very important. See that it may be properly classified. Also state CAUSE OF DEATH

Spec– 12-23-21—E.B.R.S.—400 Bks.

BARBARA KLIMA ✓

D 93885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 93885

1-PLACE OF DEATH

City of BALTIMORE: (No. 816 N. Madeira St., 7-2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Klima

(a) Residence No. 816 N. Madeira St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Paul X Klima

6-DATE OF BIRTH (month, day and year) 1st Known

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Bohemia

14- (Informant) Paul X Klima

(Address) 816 N. Madeira St.

15- Filed NOV 9 1925 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 9/25

17- I HEREBY CERTIFY, That I attended deceased from June 1 19 25 to June 9 19 25

that I last saw h[illegible] alive on June 8 19 25

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Paul Reynolds M.D.

June 9 19 25 (Address) 600 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. | DATE OF BURIAL June 11 1925

20-UNDERTAKER, Frank E. Cook & Son | ADDRESS 1900 Eastern Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93886 ✓ D 93886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 3458 Cedar Ave 13 Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sallie A Gary

(a) Residence No. 3458 Cedar Ave St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

8-SEX: F

4-COLOR OR RACE: White

5-~~Single, Married~~ Widowed, ~~or Divorced~~ (Write the word.): Widowed

5a-If married, widowed or divorced, HUSBAND of (or WIFE of): Phillip Gary

6-DATE OF BIRTH (month, day and year): Jan 10 1850

7-AGE. 74 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Ret~~
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- Informant: Anna Adelsberger (Address) 3458 Cedar Ave

15-

Filed JAN 9 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 9 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1924 to Jan 9 1925

that I last saw h[illegible] alive on Jan 9 1925

and that death occurred, on the date stated above, at 12 [illegible]

The CAUSE OF DEATH* was as follows:

Pulmonary oedema
Hypostatic congestion

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation & Dem.

(Duration) 3 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Circulation & Pericarditis

(Signed) Thos J Kelly M D

1/9, 1925 (Address) 4 Somerset Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Jan 12 1925

20-UNDERTAKER. Chenoweth & Son — ADDRESS 861 Chestnut Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1515 Baldwin St Ward) 13-3

Registered No. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Burke

(a) Residence No. 1515 Baldwin St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed,~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 20 1924

7-AGE. ..... yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER James F Burke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Nora F Burke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) James Burke

(Address) 1515 Baldwin St

15- Filed ..... 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 8 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 19.. to Jan 8 19 25

That I last saw her alive on Jan 8 19 25

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical Symptoms

(Signed) C F Lindgren M. D.

1-9 1925 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Hampden	Jan 10 19 25
20-UNDERTAKER.	ADDRESS.
Chenowith & Son	3617 Chestnut Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

Lloyd Titus

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93888

CERTIFICATE OF DEATH.

D 93888

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Titus

(a) RESIDENCE NO. 6 W. 26th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith G Titus

6 DATE OF BIRTH (month, day, and year) Mar 2 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
25	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Agent.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER Ethan A Titus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Colebrook N H

12 MAIDEN NAME OF MOTHER Hattie E Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Columbia

14 Informant Hospital Record (Address)

15 Filed JAN 10 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/25 19

17 I HEREBY CERTIFY, That I attended deceased from 12/18/24, 19 ..., to 1/9/25, 19 ., that I last saw h[illegible] alive on 1/9/25, 19 ., and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Typhoid Perforation (duration) yrs. mos. ds.

Edema of Lungs.

18 Where was disease contracted if not at place of death? ? Typhoid Perforation

Did an operation precede death? Yes Date of 1/3/25

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Colebrook, N. H. DATE OF BURIAL Jan 10 1925

20 UNDERTAKER W. E. Cook ADDRESS 502 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should write legibly. AGE should be stated. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93889

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 245 Cedar St. St., 25 Ward) Registered No. 100-001

2-FULL NAME Harvard Wittbecker

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 245 Cedar ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 20/24

7-AGE. — yrs. 1 mos. 20 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS

10-NAME OF FATHER. Charles L. Wittbecker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER. Elsie Andrew

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Charles L. Wittbecker

(Address) 245 Cedar ave Westport

15- Filed JAN 10 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 9 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1925 to Jan 9 1925.

that I last saw him alive on Jan 7 1925.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Wesley A. Hoag M. D.

Jan 9. 1925 (Address) 229 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. Jan. 10 1925

20-UNDERTAKER. George F. Rutt

ADDRESS 1335 Hartford ave.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93890

CERTIFICATE OF DEATH.

8-3 101-001 D 93890

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1500 N. Madeira St., (St.) ..... (Ward) .....

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Stigers

(a) Residence No. 1500 Madeira St., St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 24 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Stigers.

6-DATE OF BIRTH (month, day and year) Jan 6/18

7-AGE. 76 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... —
(c) Name of employer ..... —

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Stigers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mary H. Stigers
(Address) 1500 N. Madeira st

15- Filed JAN 10 1925 Robert F. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 7 25

17- I HEREBY CERTIFY, That I attended deceased from Dec 31st 1924 to Jan 7th 1925

that I last saw h living alive on Jan 7 1925

and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Reginald J Tonry M. D.

Jan 10. 1925 (Address) 414 E Mt. St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Jan 10 1925
20-UNDERTAKER.	ADDRESS
Geo. J. Ruth	1735 Hayford Ave.

In plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

17-13-93891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93891

CERTIFICATE OF DEATH.

3155

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Joseph Lorek

(a) RESIDENCE NO. 504 S Wolfe ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 5 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	-	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Stephen Lorek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Florence ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

NOV 10 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 19 25, to Jan 7, 19 25,

that I last saw him alive on Jan 7, 19 25,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

osteomyelitis hip NY - Acute exacerbation

(duration) yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia, Septicemia (P)

(duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Jan 4, 1925

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J A Sweeney, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Jan 12 1925
20 UNDERTAKER	ADDRESS
John H Weber	1803 Bank

IMPORTANT—Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Eks.

D 93892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93892

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., 25-11 101 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Bryzgalewski

(a) Residence No. 9 Cherry St Curtis Bay, Md St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 1, 1923

7-AGE: 1 yrs. 8 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS

10-NAME OF FATHER: Isador Bryzgalewski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Helen Syboski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Isador Bryzgalewski (Address) 9 Cherry St Curtis Bay

15- Filed ..... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 7, 1925

17- I HEREBY CERTIFY, That I attended deceased from Nov 21, 1924 to Jan 7, 1925

that I last saw him alive on Jan 7, 1925

and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia. -

(Duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary): Chr. emphysema -

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Home -

Did an operation precede death? Yes Date of Dec 5, 1924

Was there an autopsy? Yes -

What lesl confirmed diagnosis?

(Signed) Howell M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus

DATE OF BURIAL: Jan 10, 1925

20-UNDERTAKER: John M. Weber

ADDRESS: 1803 Bank St

JAN 10 1925

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 9-4 REGISTERED NO. 44

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Knoverk

(a) RESIDENCE NO. 2315 Taylor Ave ST., Balto Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Koubek.

6 DATE OF BIRTH (month, day, and year): June 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Taylor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

080

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Matthew Koubek.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): John J. Koubek 3920 J. Fernwood Ave

15 Filed: . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

JAN 10 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 16 '24 to Jan 8 1925.

that I last saw him alive on Jan 8 1925;

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of Dec 18-1924

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) W Wallace Walker M. D.

. 19 (Address) Lombard & Greene Sts University

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Jan. 12 1925

20 UNDERTAKER: Lilly & Zeller ADDRESS: 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE should be stated EXACTLY. PHYSICIAN'S DUTY. AGE should be carefully supplied. DATE OF DEATH should be stated EXACTLY. PHYSICIAN'S DUTY. AGE should be carefully supplied. DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 93894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 708 S. Robinson St., 1-41 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Zimmer

(a) Residence No. 708 S. Robinson St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of late John J. Zimmer

6-DATE OF BIRTH (month, day and year) Feb 17th 1853

7-AGE. 71 yrs. 10 mos. 21 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Michael Welcher

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mary M. Zimmer

(Address) 702 S. Robinson St.

15- Filed JAN 10 1925 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 7th 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 28 19 24 to Jan 7 19 25

that I last saw h[illegible] alive on 12/31 19 24

and that death occurred, on the date stated above, at 9 55 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis—

Pulmonary edema due to cardiac insufficiency.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C A Reifschneider M. D

1/9 1925 (Address) 2939 Easanave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart Cem	Jan 10 1925
20-UNDERTAKER.	ADDRESS
Lilly & Zeiler	420 S. Wolfe

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 405 N. Carrollton ave St., 18 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa F. Piquett

(a) Residence No. 405 N. Carrollton ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Piquett

6-DATE OF BIRTH (month, day and year) Oct 20. 1850

7-AGE, 74 yrs. 2 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Phila. Pa.

PARENTS:

10-NAME OF FATHER, Jos. J. Lipp

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Phila Pa.

12-MAIDEN NAME OF MOTHER, Burton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Mary G. Piquett

(Address) 405 N. Carrollton

15- Filed JAN 10 1925 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 9/25

17- I HEREBY CERTIFY, That I attended deceased from December 12 1924 to Jany 9 1925

that I last saw her alive on Jany 8 1925

and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) — yrs. — mos. 12 ds.

18-Where was disease contracted if not at place of death? St Louis

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Charles Gelb M. D.

, 19 (Address) 1111 W. Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. Jany 12 1925

20-UNDERTAKER. John Ottenhell ADDRESS 201 Lafayette Ave.

Exact statement of OCCUPATION is very important. See

In plain terms, so that it may be properly classified.

instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 93896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93896

CERTIFICATE OF DEATH.

1925

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Madison ave St. WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel W. Duvall

(Residence in Baltimore: No. 2000 Madison ave St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 23, 1850 (Month) (Day) (Year)

7-AGE, 74 yrs. 3 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...retured...
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George W. Duvall

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ruth Harker

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lelia E. Duvall

(Address) 2000 Madison ave

15-

Filed Nov 10 1925 Robert P. Harrison, Registrar. Burial Permit Clerk. John C. Mitchell

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 3, 1925 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1924, to Jan 8 1925, that I saw h im alive on Jan 8 1925, and that death occurred, on the date stated above, at 10 30 Am.

The CAUSE OF DEATH* was as follows:

Fracture, neck of right femur

(Duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) Edwin K. Ballard M. D.

1-3, 1925 (Address) 1622 Mt Royal Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? diagnosis verified by X-ray

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount DATE OF BURIAL, Jany 10., 1925

20-UNDERTAKER John C. Mitchell ADDRESS 120 W. Fayette St.

See reverse

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 93897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David Weigel

(a) RESIDENCE NO. Brooklyn N.Y. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Famir Weigel

6 DATE OF BIRTH (month, day, and year) June 20 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
66	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Peter Weigel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Genevieve Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A E Weigel

(Address) 22 14 Eutaw

15 Filed JAN 10 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 19 25

17

I HEREBY CERTIFY, That I attended deceased from Dec. 7th, 19 24, to June 10th, 19 25,

that I last saw h[illegible] alive on June 10th, 19 25,

and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Carcinoma of Bladder

(Cancer)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/30/24

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Philip Jacobson M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooklyn N.Y.	1/10 1925
20 UNDERTAKER	ADDRESS
David Londheim	1808 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Herman Greenbaum D 93898

D 93898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Aprt. V-I St., 13 Ward) REGISTERED No. 689

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Greenbaum.

(a) RESIDENCE No. Alhambra Aprt., St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie H Greenbaum

6 DATE OF BIRTH (month, day, and year) Jan. 2nd, 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Isaacs Greenbaum.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant B Hecht

(Address) Alhambra Aprt

15 Filed JAN 10 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 9th 1925

17

I HEREBY CERTIFY, That I attended deceased from Oct 3, 1924 to Jan 9, 1925

that I last saw h alive on Jan 8, 1925

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Arteri-Sclerosis,

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedenwald M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew,	Jan. 11th 1925
20 UNDERTAKER David Sondheim	ADDRESS 1417 Bank St. Royal Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Filed [illegible] Registered [illegible]

Cor.—1-12-23—M&T—100 Blks.

D 93899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 E 20½ ST. 12 WARD)

REGISTERED NO. 590

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Johnson

(a) RESIDENCE NO. 320 E 20½ ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dent/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Effie Coates

(Address) 320 E 20½ St

15 Filed JAN 10 1925, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison, M. D.
(Coroner.)

Jan 8, 192[illegible] (Address) 1522 Rolandene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 10 1925

20 UNDERTAKER Mrs R. A. Elliott ADDRESS 1525 Baltimore

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93900

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 424 E.25th St. St., 12-4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John F.Ireton,

(a) Residence No. 424 E.25th St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Blanche Ireton,

6-DATE OF BIRTH (month, day and year) Jan.5.1873

7-AGE,	If LESS than 1 day,
52 yrs. -- mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Supt. Transportation

(b) General nature of Industry, business, or establishment in which employed (or employer)... City Dept.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). New York City

PARENTS.

10-NAME OF FATHER, John Ireton,

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Sheridan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pennsylvania

14- (Informant). Mrs.Blanche Ireton,

(Address)....424 E.25th St.....

15- Filed..... 19.. Robert P. Harrison, Registrar.

JAN 10 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan.9.1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1925, to Jan 9 1925, that I last saw h in alive on Jan 9 1925, and that death occurred, on the date stated above, at 3.25P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo M Gutstein M.D.

1/11/25 (Address) 1401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral

DATE OF BURIAL, JAN 12 1925, 19..

20-UNDERTAKER, Geo W Little

ADDRESS 2700 EDMONDSON AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Also CAUSE OF DEATH. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93901

D 93901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. 38 ST., 18-1 WARD)

2-FULL NAME Solomon Henom Henson

(a) RESIDENCE NO. 1011 W. Fountain ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years: 42 Months: Days: If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant: Bay View Hospital
(Address)

15 Filed ..... 19 .....
Robert P. Harrison,
Burial Permit Clerk
Registrar

JAN 10 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7. 19 25

17 I HEREBY CERTIFY that I attended deceased from Feb. 6 ..., 19 24, to Jan 7. ..., 19 25, that I last saw him alive on Jan 7, 19 25, and that death occurred, on the date stated above, at 10-15 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical

(Signed) N. G. Edgington M. D.

1/7/25 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1-10-19 25

20 UNDERTAKER: Samuel Easton

ADDRESS 916 Eager

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Rks.

Time of [illegible] Monday Jan. 12, 1925
Dr. Mark Hemmel, Emmanuel Cook.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93902

CERTIFICATE OF DEATH.

D 93902

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. ST., 15-13 (WARD)

2-FULL NAME Thos. H. Turner

(a) RESIDENCE NO. 1728 Pinkney St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Wm. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maggie Sawyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co md.

14 Informant Maggie Turner
(Address) 1547 Bruce St

15 Filed ..... 192 ..... Registrar
Robert P. Harrison,
JAN 10 1925 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Lis death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gsw shot wound of Chest. 1/2 hr
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Homicide
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

Jan. 9 1925 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan 12 1925
20 UNDERTAKER Mrs Jas. N. Dennis	ADDRESS 1303 Presstman St
per C. E. Kelson.	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 190

City of BALTIMORE: (No. Beechfield Ave. near Frederick Rd. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Leidig

(a) Residence No. Beechfield Ave. near Frederick Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernhard Leidig

6-DATE OF BIRTH (month, day and year): June 1849

7-AGE, 75 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Longwork

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: George Heysel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): George Leidig

(Address): Beechfield Ave.

15-

Filed JAN 10 1925 19 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 9-1925

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to January 9, 1925, that I last saw h.r alive on January 8 1925 and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry J. Hill, M. D.

Jan 10 1925 (Address) 1 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan. 12, 1925

20-UNDERTAKER: George L. Schwat — ADDRESS: 1101 Fulton Ave.

Burial Permit Clerk

If the plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 93904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93904

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3926 Fait Ave St., N-6 Ward) Registered No. 90

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. W. Rau, Sr.

(a) Residence No. 3926 Fait Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate L. Rau

6-DATE OF BIRTH (month, day and year): Nov. 9- 1860

7-AGE: 64 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: John Rau

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Wilhelmina Schleuderberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs. Anna C. Brodka

(Address): 3926 Fait Ave

15- Filed JAN 10 1925

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 7-1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 6th 1925 to Jan. 7-1925

That I last saw him alive on Jan 6-25

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Thrombus Cerebral

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W. Herrmann M.D.

(Address) 2913 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Jan 11, 1925

20-UNDERTAKER: Zirkler & Zirkler — ADDRESS 1739 Eager

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

17 9417 93905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93905

CERTIFICATE OF DEATH.

X 153

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Melvin ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Gruff

(a) RESIDENCE NO. Myrth Ave, Essex, Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 9, 1924

7 AGE — Years — Months 10 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Gruff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carrie Lemar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed JAN 13 1925 Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-9 1925

17 I HEREBY CERTIFY, That I attended deceased from 1-7, 1925, to 1-9-, 1925, that I last saw him alive on , 1925, and that death occurred, on the date stated above, at 12 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute abdominal abscess

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 7

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland

DATE OF BURIAL: Jan 12 1925

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS 1739 Eager

CAUSE OF DEATH must be stated EXACTLY. PHYSICIAN'S should be stated plainly. AGE should be stated in every case. Every item must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—409 Blks.

D 93906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1520 N. Washington St., 8-3 Ward)

Registered No. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bonn

(a) Residence No. 1520 N. Washington St., Ward

(I'sual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 25, 1878

7-AGE. 46 yrs. 3 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Louis V. Bonn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER. Kate Owens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14- (Informant) Viola Gardner

(Address) 2116 N. Wolfe

15- Filed JAN 10 1925 Robert P. Harrison. Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 9, 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 7, 1925 to Jan 9, 1925

that I last saw h alive on Jan 9, 1925

and that death occurred, on the date stated above, at 8.25 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleuro Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris J. Sadek M. D.

1/9, 1925 (Address) 3523 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL, Jan 13, 1925

20-UNDERTAKER. Zirkler & Zirkler

ADDRESS 1739 Eager

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

93907

HEALTH DEPARTMENT—CITY OF BALTIMORE

93907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SOUTH BALTO GEN'L HOSP. ~~DET.~~ 13-5-88 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MRS HELEN DEVILBISS

(a) RESIDENCE NO. 2800 PARKWOOD AVE. ~~ST.~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEMALE

4 COLOR OR RACE: WHITE

5 Single, Married, Widowed, or Divorced, (write the word): MARRIED

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ FREDERICK DEVILBISS

6 DATE OF BIRTH (month, day, and year) OCT. 7 1902

7 AGE — Years: 22 — Months: 3 — Days: 1 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: HOUSEWIFE

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): BALTIMORE MD

PARENTS

10 NAME OF FATHER: EDWARD NORRIS

11 BIRTHPLACE OF FATHER (city or town) (State or country): HARKSVILLE MD

12 MAIDEN NAME OF MOTHER: ELIZABETH LOWE

13 BIRTHPLACE OF MOTHER (city or town) (State or country): HARKINS MD

14 Informant: MR FREDERICK DEVILBISS (Address) 2800 PARKWOOD AVE

15 Filed NOV 10 1925 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN. 8, 1925.

17 I HEREBY CERTIFY, That I attended deceased from NOV 11, 1924, to JAN 8, 1925, that I last saw HER alive on JAN 8, 1925 and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

BACTERIAL ENDOCARDITIS

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ACUTE NEPHRITIS

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? SIGNS & SYMPTOMS

(Signed) J. P. Peterman, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Jan 12 1925

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

93908

HEALTH DEPARTMENT—CITY OF BALTIMORE

93908

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1602 N. Montford Ave (St.) 8-2 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Benjamin Adams

(a) RESIDENCE NO. 1602 N. Montford ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 29th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles A. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys

12 MAIDEN NAME OF MOTHER Benedicta Bean

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co

(State or country)

14 Informant Charles Adams

(Address) 1602 N. Montford ave

15 Filed JAN 10 1925, 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan. 6 1925 to Jan. 8 1925

that I last saw him alive on Jan. 8 1925

and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1602 Montford Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack H. Horgan M. D.

19 (Address) 62 West St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetary — DATE OF BURIAL: Jan 10th 1925

20 UNDERTAKER: Frank V Pepitone — ADDRESS: 1800 E 82 nd

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93909

CERTIFICATE OF DEATH.

57 V

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 21-3 WARD)

2-FULL NAME George E.Burke.

(a) RESIDENCE No. 1125 Scott St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of !!!!!!!!!!!!

6 DATE OF BIRTH (month, day, and year) December 24, 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	0	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Assistant foreman,
(b) General nature of industry, business, or establishment in which employed (or employer) Hannis Distillery.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Franklin D.Burke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Georgetta Barrett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant James H. Burke. (brother)
(Address) 1125 Scott St.

15 Filed JAN 10 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jany 8th. 1925 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan 10 1925
20 UNDERTAKER	ADDRESS
Roby J. Cowan & Son	901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

D 93910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93910

CERTIFICATE OF DEATH.

25-2 127

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St Agnes Hos Fulton ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Unclear B O'Malley

(a) RESIDENCE NO. Rolling Rd - St Dennis ST., WARD St. Dennis Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel O'Malley

6 DATE OF BIRTH (month, day, and year) Mch 17 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Coal and Lumber

(c) Name of employer Proprietor

9 BIRTHPLACE (city or town) (State or country) Eastridge - Md

PARENTS

10 NAME OF FATHER Patrick O'Malley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Hennelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John F. Malley

(Address) Eastridge, Md.

15 Filed JAN 10 1925, 19 ROBERT E. HARRISON Clerk

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1925

17

I HEREBY CERTIFY, That I attended deceased from January 5th, 1925, to January 8th, 1925, that I last saw alive on January 8th, 1925, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic cholecystitis

(duration) 14 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute pancreatitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Jan 8th 25

Was there an autopsy? Yes.

What test confirmed diagnosis? Gross pathology.

(Signed) Frederic J. Bohrer, M. D.

Jan 8, 1925 (Address) Relay - Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Augustine's Cem Eastridge Md	Jan 12 1925
20 UNDERTAKER John J Cowan & Son.	ADDRESS
Ted F. J. Cowan	90 Holliday

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93911

1-PLACE OF DEATH

City of BALTIMORE: (No. 313 N. Carey St. St., 18-1 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Caldwell

(a) Residence No. 313 N. Carey St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of the late Nellie Caldwell

6-DATE OF BIRTH (month, day and year) Feb 6, 1850

7-AGE, 74 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, Caldwell

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Beatrice A. Caldwell

(Address) 505 N. Schroeder St.

15- Filed JAN 10 1925, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 8, 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1924 to Jan. 8, 1925 that I last saw h. alive on Jan. 8, 1925 and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Frank N. Ogden, M. D.

, 19 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Jan 9, 1925

20-UNDERTAKER, Harry H. Weitzke — ADDRESS 1831 W. Lombard St

IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93912

CERTIFICATE OF DEATH.

4-1 100-001 D 93912

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 4-1 WARD)

2-FULL NAME Thomas L. Bailey.

(a) RESIDENCE No. 604 W. Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Sidonie Bailey

6 DATE OF BIRTH (month, day, and year) July 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Koch Importing Co

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Sidonie Bailey (Address) 604 W. Lombard St.

15 Filed ....., 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8-25

17

I HEREBY CERTIFY, That I attended deceased from 1-7-25, 19..., to 1-8-25, 19..., that I last saw h[illegible] alive on 1-8-25, 19..., and that death occurred, on the date stated above, at 7.20 m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

19..... (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Jan 10 1925

20 UNDERTAKER Jos Joerdens Son ADDRESS 2173 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 93913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93913

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklintg Hosp ST. 21-3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalie Portera

(Residence in Baltimore: No. 782 Washington Blvd. St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept 25 (Month) (Day), 1912 (Year)

7-AGE, 12 yrs. 3 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Portera

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Sadie Tarsia

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Portera

(Address) 787 Washington Blvd.

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

JAN 10 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 9th (Month) (Day), 1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1925, to Jan 9 1925, that I saw her alive on Jan 9 1925, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration).....yrs.....mos....1...ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Wm. Krempley M. D.

....., 191... (Address) 1013 Poplar Grove.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	June 12.., 1925
20-UNDERTAKER	**ADDRESS**
Clarence T. Krempley	776 Fonburg

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

See Letter on file from Dr C. G. Grace 2-16-25

D 93914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 15-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gibbs

(a) RESIDENCE NO. 1616 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862 ~~85~~ 5

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63 7 0			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 4 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Gibbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Penn & 10th (Address)

15 Filed JAN 10 1925 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1925

17 I HEREBY CERTIFY, That I attended deceased from 12-27, 1924, to 1-7, 1925, that I last saw him alive on 1-7, 1925, and that death occurred, on the date stated above, at 12¹⁰ a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) Claude G. Grace M. D.

1-7, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DEPT. OF PUBLIC HEALTH HOSPITALS

DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health, Per. Wm. R. Wossilus

ADDRESS JAN 10 1925

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93915

HEALTH DEPARTMENT—CITY OF BALTIMORE

93915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5-1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hines

(a) RESIDENCE NO. 101 Front ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER John Hines

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—8 1925

17

I HEREBY CERTIFY, That I attended deceased from 12-12, 1924, to 1—8, 1925

that I last saw him alive on 1—8, 1925

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) Claude C. Dove, M. D.

1-8, 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: JAN 10 1925

20 UNDERTAKER Commissioner Health, — ADDRESS .....
For Wm. S. Hessler

4/10 1925 (0039)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should study CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93916

D 93916

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2-1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Schecter

(a) RESIDENCE No 1924 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of nnnnnn

6 DATE OF BIRTH (month, day, and year) Dec 28/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11/2 hours			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Max Schecter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ruth ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknwon

14 Informant Hopkins Hospital
(Address)

15 Filed JAN 10 1925, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28-24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity 6 1/2 Months Gestation
(Autopsy at Hospital)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Cullen (Coroner.), M. D.

Jan 8, 1925 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER Bureau of Vital Statistics, — ADDRESS

Per Wm. E. WOODALL

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 93917

CERTIFICATE OF DEATH.

D 93917

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Johns Hopkins Hospital ST., 7-1 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Boy" Johnson

(a) RESIDENCE NO. 803 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of))))

6 DATE OF BIRTH (month, day, and year) Jan 4-25

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Maud Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hopkins Hospital
(Address)

15 Filed JAN 10 1925 16 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5-25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(Autopsy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Falk, M. D.
(Coroner.)

1-8-25, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

JAN 10 1925

(R.37)

FOR USE OF MORGUE

JAN 10 1925

Exact statement of OCCUPATION is very important See instructions on back of certificate. May be properly classified.

Cor.—1-12-23—M&T—100 Bks.

D 93918 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93918

CERTIFICATE OF DEATH. 180-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) (2) Walter P. Opher ST., 5-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (1) 534 N. Eden St

(a) RESIDENCE NO 534 N. Eden st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 28-24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Walter Opher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Opher
(Address) 534 N. Eden St

15 Filed JUL 1925, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8-25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocation by bed clothes
Accidental

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Hall, (Coroner) M. D.

Jan 10-25 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL 1/10/25 192

20 UNDERTAKER R C Goos — ADDRESS 1405 McElderry St

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93919

CERTIFICATE OF DEATH.

D 93919

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 East St.; 5-1 WARD)

2-FULL NAME Ethel Smith

(a) RESIDENCE. NO. 122 East St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Smith

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Drusilla Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Sudie Ruffin

(Address) 47 Watson st.

15 Filed JAN 10 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 - 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1925, to Jan 4, 1925, that I last saw h.. alive on Jan 3, 1925, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns M. D.

1-9-25 (Address) 2017 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/12/25 19

20 UNDERTAKER R L Gross

ADDRESS 1405 McElderry

Section should be carefully supplied. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Hetz)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93920 D 93920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE; (No. Lombard & Greene Sts. 1ST., 9-1 WARD)

REGISTERED NO. 127

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Hetz

(a) RESIDENCE No. 820 E. 33rd St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Hetz

6 DATE OF BIRTH (month, day, and year) May 26 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Rolf Hetz

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Louise Sendelbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Elizabeth Hetz (Address) 820 E. 33rd St.

15 Filed Jan 10 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1925, to Jan. 7, 1925, that I last saw him alive on Jan. 7, 1925, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes Date of Jan. 3, 1925.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. Gordon McCullough, M. D.

19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1/11/ 1925
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93921

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 219 S Fremont ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Miller

(a) Residence No. 219 S. Fremont St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 12/27/24

7-AGE, 1 yrs. 13 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Rogers Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), S. C.

12-MAIDEN NAME OF MOTHER, Delia Erven

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), S. C.

14- (Informant) Rogers Miller

(Address) 219 S Fremont ave

15- Filed JAN 10 1925, 192 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/9/25

17- I HEREBY CERTIFY, That I attended deceased from 1/7/25 to 1/9/25

that I last saw h alive on 1/9/25

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

Acute (Duration) yrs. mos. 3 ds.

CONTRIBUTORY Chr Rheumat

(Secondary) Bronchitis Acut (Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? no !

Did an operation precede death? no Date of —

Was there an autopsy? no, Obvious

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/10, 1925 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodburn cemetery — DATE OF BURIAL, Jan 10, 1925

20-UNDERTAKER, Edward Bryon — ADDRESS 634 Orleans St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Underlying CAUSES should state CAUSE OF DEATH instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mount Hope Retreat St. 28-174 Ward) Registered No.....

2-FULL NAME... Mrs Margaret Haverty. HANRATTY.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. Mount Hope Retreat St., 28 Ward Philadelphia, Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Doubtyrs. knownmos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ ~~HUSBAND of (or)~~ WIFE of Mr Haverty-

6-DATE OF BIRTH (month, day and year) Abt 1842 (?)

7-AGE. abt 83 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (?)
(State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Harold

11-BIRTHPLACE OF FATHER (city or town) Co. Donegal
(State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret Derr

13-BIRTHPLACE OF MOTHER (city or town) (?)
(State or Country), Ireland

14- (Informant) Records of Mt Hope
(Address) Balto Md.

15- Filed JAN 12 1925 19.. Robert L. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 10, 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1923 to Jan 10 1925, that I last saw h.. alive on Jan 9 1925, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage causing
R. Hemiplegia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Chr. Man. Psychosis

Abt (Duration) 2 2 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Philadelphia Pa. DATE OF BURIAL, Jan 12 1925

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. ...CAUSE OF DEATH... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93923

CERTIFICATE OF DEATH.

74-001

D 93923

1-PLACE OF DEATH Church Home + Infirmary Registered No.....

City of BALTIMORE: (No.....St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Straughn

(a) Residence No. Mount Royal Apartments St., (not hospital etc. 44) Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Groome Straughn

6-DATE OF BIRTH (month, day and year) Jan 24-1852

7-AGE. 72 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Government

9-BIRTHPLACE (city or town) Easton (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, John Straughn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rose

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Ella G. Straughn

(Address) Mt. Royal Apts. Cathedral + Mt. Royal Ave.

15- Robert F. Harrison,

Filed ..... 192..... Registrar.

Burial Permit Clerk.

JAN 10 1925

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 9 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1924 to Jan 9 1925

that I last saw him alive on Jan 9 1925

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arterio Sclerosis

(Duration) ..... yrs. ..... mos. 2 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Keith C. Rice M. D

19 (Address) Church Home + Infirmary

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Easton Md.	Jan 10 1925
20-UNDERTAKER.	**ADDRESS**
H. E. Hughes	444 N. Broadway

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. ...ED ENROLLED PHYSICIANS should state CAUSES OF DEATH ...ertified. ...instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Blks.

Fritter

HEALTH DEPARTMENT—CITY OF BALTIMORE

93924

CERTIFICATE OF DEATH.

D 93924

1-PLACE OF DEATH St. Joseph's Hosp. 8-4 Registered No.....

City of BALTIMORE: (No..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Fritter

(a) Residence No. 1314 N. Montford St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F. | 4-COLOR OR RACE, W. | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~(or) WIFE~~ of wife of Richard Fritter

6-DATE OF BIRTH (month, day and year) May 2 1883

7-AGE, 41 yrs. mos. ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.
10-NAME OF FATHER Nicholas Kinnucci
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va
12-MAIDEN NAME OF MOTHER Mary Giffini
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Richard A Fritter
(Address) 1314 N. Montford

15- Filed JAN 11 1925 ADOLPH H. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 9-1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 - 1925 to Jan 9 - 1925
that I last saw her alive on Jan 9, 1925
and that death occurred, on the date stated above, at 10 30 p. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis mtl
Hypertension
(Duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Apoplexy
(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) P. B. Sybert M. D
19 (Address) Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Vienna Va | DATE OF BURIAL, Jany 11 1925

20-UNDERTAKER, Ralph Shriver | ADDRESS 14 x 2

Embalmed

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93925

CERTIFICATE OF DEATH.

90 D 93925

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ..... ST. 10-2 WARD)

2-FULL NAME Frances Lasover

(a) RESIDENCE NO. 820 N. Gay ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.
(If non-resident give city or town and State)

ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Lasover

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hsw

(b) General nature of industry, business, or establishment in which employed (or employer) 131

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Lasover

(Address) 820 N. Gay St.

15 Filed JAN 11 1925, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10, 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1924, to Jan. 10, 1925, that I last saw h[illegible] alive on Jan 10, 1925, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; bronchitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & lab.

(Signed) Isidor S. Fry, M. D.

Jan 1925 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest DATE OF BURIAL 1/11 1925

20 UNDERTAKER Jack Louis ADDRESS 489 E. Balt St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93926

D 93926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 S Patterson Park Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Dann

(a) RESIDENCE No. 26 S Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Dann

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailoring
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Louis Dann
(Address) New York

15 Filed ..... 192 ..... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9/25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows: Arterial Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

(Signed) Geo. Louis Blades M. D.
(Coroner)

Jan 9/25 192 (Address) 145 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL Jan 11 192 5

20 UNDERTAKER Jack Levin ADDRESS 1409 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93927

CERTIFICATE OF DEATH.

74-001

D 93927

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1211 Hanover St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Krebs

(a) Residence No. 1211 Hanover St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 2nd 1881

7-AGE. 44 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Shirt Cutter
(b) General nature of Industry, business, or establishment in which employed (or employer). 686
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Krebs

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germy.

12-MAIDEN NAME OF MOTHER. Wilhelmina Kirchner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germy.

11-
(Informant) Emma J. Krebs
(Address) 1211 Hanover st

15-
Filed JAN 11 1925 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 10th 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 8th 1925 to Jan 10th 1925
that I last saw him alive on Jan 9th 1925
and that death occurred, on the date stated above, at 7 45 a. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M.D.

1/11 1925 (Address) 1224 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Park Cem	Jan 13 1925
20-UNDERTAKER.	ADDRESS
E. Schloman & Son	1084 Hanover st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93928

CERTIFICATE OF DEATH.

401-001 D 93928

1-PLACE OF DEATH

City of BALTIMORE: (No. Paca St Mt Hospital St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Green

(a) Residence No. Paca St Mt Hospital St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, Colored | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Don't Know

7-AGE 58 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Don't Know

14- (Informant) Geo Green

(Address) Paca St

15- JAN 11 1925 ROBERT F. KRAUTER, Registrar. Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-9-25

17- I HEREBY CERTIFY, That I attended deceased from 1-9-, 1925 to 1-9-, 1925

that I last saw h[illegible] alive on 1-9-, 1925

and [illegible]th occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Lob Pneumonia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Grip

(Duration) yrs. mos. 3 ds. 2

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Reed Dram, M. D.

, 19 (Address) 1 [illegible] Mt Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dist Columbia | DATE OF BURIAL. 1-12-25

20-UNDERTAKER Dunn Funeral Co | ADDRESS 946

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93929

REGISTERED NO. 17 D 93929

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 W. Franklin St. ST., 17-3 WARD)

2-FULL NAME Wm. H. Blagmond

(a) RESIDENCE NO. 818 W. Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Blagmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lilly Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. Blagmond
(Address) 818 W. Franklin St.

15 Filed JAN 11 1925 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. appendicitis

(duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Jan. 10, 1925 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	1-11-1925.
20 UNDERTAKER Daniel Easton	ADDRESS 976 Pe Ave

IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93930

CERTIFICATE OF DEATH.

90

D 93930

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 688 Sundberry ST., 17-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Rogers

(a) RESIDENCE NO. 688 Sundberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 Informant Eddy Rogers
(Address) 688 Sundberry St.

15 Filed JAN 11 1925, 19 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1925 to Jan 9, 1925, that I last saw h[illegible] alive on Jan 9, 1925, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Mackley, M. D.

1/10/1925 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 1-13-25

20 UNDERTAKER Daniel Corbin ADDRESS Penn

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Eks.

D 93931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1220 argyle St., 17-10 Ward)

Registered No. 1-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Nelson

(a) Residence No. 1220 argyle St., one Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1899

7-AGE: 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Jamaica

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (City or Town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-

(Informant): Miss Nellie Honduras

(Address): 1220 argyle ave

15-

JAN 11 1925

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1-8-1925

17- I HEREBY CERTIFY, That I attended deceased from January 4th 1925 to January 8th 1925, that I last saw him alive on January 8th 1925, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Burwell Fargo M. D.

, 19 (Address) 2937 N. Gilbert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 1-11-25

20-UNDERTAKER: Wm F Corbett

ADDRESS: 96 N

Be sure and state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 93932

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2102 Huntingdon Ave ST., 17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Lindemon

(a) RESIDENCE No. 2102 Huntingdon Ave ST.
(Usual place of abode)

WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (Write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 1864

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Saw mill Lumber

(c) Name of employer Chas E Kemper

9 BIRTHPLACE (city or town) Balto Co
(State or country)

PARENTS

10 NAME OF FATHER Henry Lindemon

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Forest

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country)

14 Informant Mrs. M A Long
(Address)

15 Filed JAN 11 1925, 19 ROBERT R. KRAMER Registrar

Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17

I HEREBY CERTIFY, That I attended deceased from August, 1924, to Jan. 9, 1925, that I last saw him alive on Jan 8, 1925, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Coronary Throm

(duration) Several yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 20, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Church Cemetery

DATE OF BURIAL Jan 13 1925

20 UNDERTAKER W. C. Brooks

ADDRESS Sparks Md

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93933

CERTIFICATE OF DEATH.

51

D 93933

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 Mc Cabe Ave St., 27-9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton F. Poehlitz

(a) Residence No. 618 Mc Cabe Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE~~ of Anna H. Poehlitz

6-DATE OF BIRTH (month, day and year) Jan. 17 1898

7-AGE. 26 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Chauffeur for
(b) General nature of industry, business, or establishment in which employed (or employer)..... J. Van Dell Co
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS:

10-NAME OF FATHER. Paul F. Poehlitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Reese

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Anna H. Poehlitz
(Address) 1231 E Eager St

15- JAN 11 1925 ROBERT L. KRAMER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 9 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1924 to Jan 9 1925 that I last saw him alive on Jan 9 1925 and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

1925 (Address) 1202 E Madison St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cemetery — DATE OF BURIAL. Jan. 12 1925

20-UNDERTAKER. Henry Hoerdt Son — ADDRESS 1301 E Eager St

over

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93934

CERTIFICATE OF DEATH.

5-2 38 D 93934

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1242 Edward ST., 5 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Corinne Boyd

(a) RESIDENCE NO 1242 Edward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Boyd

6 DATE OF BIRTH (month, day, and year) March 4-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Martha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Annie Jones (Aunt)
(Address) 1242 Edward St

15 Filed JAN 11 1925 192 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Secondary anaemia-malnutrition

(over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

(Signed) J. H. Allen (Coroner.), M. D.

1-9-25, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Jan 11 1925

20 UNDERTAKER Samuel F. Hensley ADDRESS 578 N Bradford St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93935

CERTIFICATE OF DEATH.

D 93935

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. Turley Ave ST., 26-1 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mrick

(a) RESIDENCE NO. Turley Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Mrick

6 DATE OF BIRTH (month, day, and year) Oct 9th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	74	3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) " " "
(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Samuel Register
(Address) Turley Ave

15 Filed JAN 11 1925 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/25

17 I HEREBY CERTIFY, That I attended deceased from Jany 6, 1925, to Jany 9, 1925, that I last saw h[illegible] alive on Jany 9, 1925, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas L Lorge M. D.

, 19 (Address) Cor Fulton & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan. 13 1925

20 UNDERTAKER Frank Lessner & Sons — ADDRESS Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 Cole Ave. Roseberry ST. [illegible] WARD)

REGISTERED NO. 11-606

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Heiss

(a) RESIDENCE No. 13 Cole Ave. Roseberry ST., WARD 26
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Matilda Heiss

6 DATE OF BIRTH (month, day, and year) March 23 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	78	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Shrewsbury
(State or country) Penn

PARENTS

10 NAME OF FATHER Henry V. Heiss

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Matilda Heiss
(Address) 13 Cole ave.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1925, to Jan 9, 1925, that I last saw him alive on Jan 9, 1925, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia from Influenza (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

1, 10, 1925 (Address) Roseberry.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 12 1925

20 UNDERTAKER Fredk Loeschner Sons — ADDRESS Fullerton

---

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

D 93937 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93937

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 N. Carey St., St., 15-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Ephraim & Maud Williams

(Residence in Baltimore: No. 1313 N Carey St St.; yrs..... mos.... 7 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Jan (Month) (Day) 1925 (Year)

7-AGE. ....yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER. Ephraim Williams

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Maud Wilson

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ephraim Williams

(Address) 1313 N Carey St

15-

Filed ..... 19.....

JAN 11 1925 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day) 1925 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said the (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent Ovale

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) no autopsy

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Jan. 10, 1925. (Address) 702 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. Jan 12, 1925

20-UNDERTAKER. Hamme & Wright ADDRESS 1619 Mass Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1313 N. Carey St. St., 13-13 Ward

Registered No. B 93938

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud Williams

(a) Residence No. 1313 N Carey St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ephraim Wilson

6-DATE OF BIRTH (month, day and year) 1902

7-AGE. 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia Deluwa

PARENTS.

10-NAME OF FATHER Henry Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Jane Boulden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14-INFORMANT. (Informant) Ephraim Williams

(Address) 1313 N Carey St

15- JAN 11 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 10. 25

17- I HEREBY CERTIFY, That I attended deceased from June 9 1924 to Jan 10 1925

that I last saw h alive on Jan 10 1925

and that death occurred, on the date stated above, at 2.05 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pregnancy

Jan. 6 25 (Duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D

, 19 (Address) Cor Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount

DATE OF BURIAL, Jan 13, 1925

UNDERTAKER, Clarence E. Wright

ADDRESS 1364 Mary

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks. Thomas Giannacini

93939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 93939

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. St. Joseph's Hospital 1-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Giannacini Thomas

(a) Residence No. W. Hamilton Ave St., West of Herring Run Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. / How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: m

4-COLOR OR RACE: w

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. ~ yrs. ~ mos. ~ ds. If LESS than 1 day, 1 hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Thomas Giannacini

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Catherine Bacigalupo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14- (Informant) Mrs Henry Theriago

(Address)

15- Filed JAN 11 1925 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 9-25

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h.....alive on ..... 19.....

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia pallida

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Sybert M. D

1-10, 1925 (Address) St. Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral

DATE OF BURIAL. 1/11/25, 19....

20-UNDERTAKER. Frank V. Pakstone

ADDRESS 1801 E 32nd st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

93940

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 101-001 93940

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 890 W Baltimore ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARGARETA BRADUNAS OR WALLACE

(a) RESIDENCE No. 890 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bradunas

6 DATE OF BIRTH (month, day, and year) April 8.1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Talor

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER Vincet Wosilus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER M. Sarpalus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant John Bradunas (Address) 890 W Baltimore Street

15 Filed ..., 19 ... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

JAN 11 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/25 19

17

I HEREBY CERTIFY, That I attended deceased from 1/2/, 19 25, to 1/9/, 19 25,

that I last saw h alive on 1/9/25, 19 ,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. Sixty mos 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs Double Pneumonia

(Signed) Bernard J Tarry, M. D.

1/10, 19 (Address) 9 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WILKES BARRE PA.	Jan 12 1925
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Miss Sobelewski

HEALTH DEPARTMENT—CITY OF BALTIMORE

Sobelewski 100-001 D 93941

93941 D

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3036 Boston St., 1-4 WARD)

2-FULL NAME Sobelewski, Joseph

(a) RESIDENCE No. 3036 Boston, St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Sobelewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Vidra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Bayview Hospital

15 Filed ..., 19... Robert R. Krauter, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 8 1925

17 I HEREBY CERTIFY, That I attended deceased from 12/23, 1924, to 1/8, 1925, that I last saw him alive on 1/8, 1925, and that death occurred, on the date stated above, at 4:45 p. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) ? Syphilis of aorta paralysis of insane (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No Lab. or clinical findings

What test confirmed diagnosis?

(Signed) H. J. Schmidt M. D.

1/9, 1925 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 12 1925

20 UNDERTAKER Stephen J. Trulkowski ADDRESS 1020 Lemmon St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAPER mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1085 Monroe ST., 20-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice V Long

(a) RESIDENCE No. 1085 Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas E. Goodman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wells

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Elsie Long
(Address) 108 E. Monroe st

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Jan 9, 1925.

that I last saw her alive on Jan 8, 1925.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma of forehead and right eye

from which (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Grosham, M. D.

Jan 10 1925 (Address) 3100 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL? London Park — DATE OF BURIAL Jan 12th 1925

20 UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Shuey.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93943

CERTIFICATE OF DEATH.

100-001 D 93943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [redacted] 2420 Washington Blvd. WARD) 25-3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Shuey.

(a) RESIDENCE. NO. 2420 Washington Blvd. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Shuey.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 83	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George W. Shuey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant J. J. Nagle

(Address) 2325 Old York Road

15 Filed JAN 11 1925 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1925.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1925, to Jan 9, 1925; that I last saw h~~im~~ alive on Jan 8, 1925, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchs pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocarditis

0 (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Chas. S. Haslett, M. D.

, 19 (Address) 1730 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National	Jan 12 1925

20 UNDERTAKER W. H. Cook

ADDRESS 5322 Gorsuch

be stated EXACTLY. PHYSICIANS should state be properly classified. Exact statement of OCCUPA- of certificates.

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back

Spec– 12-23-21–E.B.R.S.–400 Eks.

Eigeldinger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93944

CERTIFICATE OF DEATH.

D 93944

1-PLACE OF DEATH Church Home and Infirmary — Registered No.....

City of BALTIMORE: (No. North Broadway St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Eigeldinger

(a) Residence No. # 1 Wheeler Ave St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Conrad Eigeldinger

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Germany

14-

(Informant) Lena Kaas

(Address) 1 North Wheeler Ave

15-

Filed JAN 11 1925 19.. [illegible] Registrar.

Social Service Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1 - 10 - 25

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1925 to Jan 10 1925

that I last saw h.. alive on Jan 10 1925

and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

Pulmonic Disease

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Keith C. Reed M. D

19 (Address) Church Home & Inf

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	Jan 13 1925
20-UNDERTAKER.	ADDRESS
Wm Cook	522 E Lexington Ave

Should be carefully applied. Also should be stated EXACTLY: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93945

CERTIFICATE OF DEATH.

D 93945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St. 8-4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Ella Woodward

(a) RESIDENCE No. 1252 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Katherine Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Miss Ella Woodward
(Address) 1252 N. Broadway

15 Filed ..... 19 ..... PUBLIC H. KRAUTER, Registrar
Burial Permit Clerk.

JAN 11 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10 1925

17 I HEREBY CERTIFY, That I attended deceased from 12-30 ..., 1924, to 1-10 ..., 1925.
that I last saw her alive on 1-10 ..., 1925.
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

General Carcinomatosis of Abdominal Viscera. (Pelvic origin)
Chronic Myocarditis; Chr Nephritis.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial failure
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of (?) St. Joseph's Hospital
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Surgical

(Signed) Thos. Youngmann M. D.
..., 19 (Address) M D Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 13 1925

20 UNDERTAKER W. Cook — ADDRESS 832 E Fayette

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1724 33 93946

CERTIFICATE OF DEATH.

90 D 93946

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 18-1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Thelma Wagner

(a) RESIDENCE NO. 900 N. Mulberry St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	3	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ada Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 11 1925 19.. RUSSELL M. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9, 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1925, to Jan 9, 1925, that I last saw her alive on Jan 9, 1925, and that death occurred, on the date stated above, at 11:08 m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

myocardial failure

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [redacted] M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 13 1925

20 UNDERTAKER Wm Cook — ADDRESS 502 E Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

10-1

D 93947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Forest ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Allsion

(a) RESIDENCE NO. 1100 Forest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced, (write the word)~~
Male	white	widower

5a If ~~married~~, widowed, ~~or divorced~~, HUSBAND of ~~(or) WIFE of~~ Mary A. Allsion

6 DATE OF BIRTH (month, day, and year) Apr 12, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairy Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York Pa.
(State or country)

PARENTS

10 NAME OF FATHER John Allsion

11 BIRTHPLACE OF FATHER (city or town) York
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Reider

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Emma Rayfield
(Address) 1100 Forest ST

15 Filed JAN 11 1925, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7, 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 5 1925 to Jan 8 1925.

that I last saw h[illegible] alive on Jan 9 1925

and that death occurred, on the date stated above, at 7 00 m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McPherson, M. D.

1-10 1925 (Address) 7255 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters, York, Pa. DATE OF BURIAL: Jan 12 1925

20 UNDERTAKER: Chas Leo & Son E. Lexington ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Forsythe 1245 Guilford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93948

CERTIFICATE OF DEATH.

90 D 93948

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 Greenmount Ave St., 9-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles E Hoddinott

(a) Residence No. 1917 Greenmount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W.	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary G Hoddinott

6-DATE OF BIRTH (month, day and year) Nov 22 1848

7-AGE,	If LESS than 1 day,
76 yrs. 9 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stockjobber

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER. George Hoddinott

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER. Elizabeth Hoddinott

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Wm E Hoddinott

(Address) 1917 Greenmount Ave

15-

Filed ..... 1925 by ROBERT R. KRAMER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1925 to Jan 9 1925 that I last saw h[illegible] alive on Jan 9 1925 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Knight Forsythe M. D.

1, 11 1925 (Address) 424 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Parkwood	Jan 13 1925

20-UNDERTAKER	ADDRESS
Wm Cook	502 E Monument Ave

Instructions: Items must be answered. Not applicable, write "None." Where unknown, so state. Cause of death must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93949

CERTIFICATE OF DEATH.

D 93949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3415 E. Fairmount ST., 96-3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Klumpp

(a) RESIDENCE No. 3415 E. Fairmount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Ida A. Klumpp

6 DATE OF BIRTH (month, day, and year) Oct 5/62

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saw Filer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Michael Klumpp

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Louisa

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Geo. Kropp
(Address) 115 N. Rose St

15 Filed ..... 19 ..... ROBERT B. KRAUTER, Registrar
JAN 11 1925 Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 1925 to Jan 9 1925

that I last saw h... alive on ... 19 25,

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) ... yrs. ... mos. 30 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. P. B. Engle, M. D.

1/10 1925 (Address) 830 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 1/12 1925

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Orleans

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93950

8-390

D 93950

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2407 E. Federal ST., (8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie K. Banton

(a) RESIDENCE No. 2407 E. Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Geo. W. Banton

6 DATE OF BIRTH (month, day, and year): Feb 16/57

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Mr Sargent

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs. M. H. Bryan

(Address): 2407 E. Federal St

15 Filed JAN 11 1925 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/10 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1925 to Jan 10 1925.

that I last saw her alive on Jan 10 1925.

and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) acute decompensation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lyman J. Abbott, M. D.

, 19 (Address) 1832 N. Carlton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Balto Cem.

DATE OF BURIAL: 1/13 1925

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Aliceanna

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 93951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1925 D 93951

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 19-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William Peal

(Residence in Baltimore: No. 232 N. Gilmor St.; yrs., (8 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. July (Month) 11 (Day) 1872 (Year)

7-AGE. 52 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Jefferson. S. C.

PARENTS.

10-NAME OF FATHER. Edward Peal

11-BIRTHPLACE OF FATHER, (State or Country). S. C.

12-MAIDEN NAME OF MOTHER. Jane Peal

13-BIRTHPLACE OF MOTHER, (State or Country). S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Peal

(Address) Detroit Mich

15-

Filed ..... 19?.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 8, 1925 (Month) (Day) (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an (autopsy) inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab wounds in back and abdomen.

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Hennessy, M. D. (Coroner.)

Jan. 10 1925 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs. 8 mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence South Carolina

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Jefferson S. C. Jan 11 1925

20-UNDERTAKER. ADDRESS

Sam'l W. Chase Inc. 1400 Mosher

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D 93952 — 1 D 93952 — 1 D 93952

CERTIFICATE OF DEATH.

T 71-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. D 93952

CITY OF BALTIMORE: (No. ..... ST., 7-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jackson

(a) RESIDENCE NO. Belair, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	10	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Belair, Md.

PARENTS

10 NAME OF FATHER: Norman Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Etta League

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 11 1925 ADELIA R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1925, to Jan 10, 1925, that I last saw h[illegible] alive on Jan 10, 1925, and that death occurred, on the date stated above, at 9:50 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus - post-meningitis

(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Belair Md

Did an operation precede death? Yes Date of Jan 10, 1925

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Firor M. D.

11, 1925 (Address) J. Hopk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Belair Md — DATE OF BURIAL: Jan 11 1925

20 UNDERTAKER: John O Mitchell — ADDRESS: 124 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93953

CERTIFICATE OF DEATH.

3-2 49

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 E. Pratt St., St., 3-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Neprotovsky

(a) Residence No. 1510 E. Pratt St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Neprotovsky

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
64 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Grocery

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) J. Lewis

(Address) 1439 E. Balto. St.,

15- Filed JAN 11 1925 19.. ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-11-25

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 24 to Jan 11 19 25

that I last saw him alive on Jan 10 19 25

and that death occurred, on the date stated above, at 7.30A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder and prostate

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Spring 1924

Was there an autopsy? No

What test confirmed diagnosis? laboratory

(Signed) A F Ries, M. D.

Jan 11, 1925 (Address) 24 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Fairview Rosedale	1-11- 19 25
20-UNDERTAKER.	ADDRESS
Jas T Lewis	1439 Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 93954

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 507 N. Hoffman ST., 17-2 WARD)

2-FULL NAME John Ellis

(a) RESIDENCE NO. 507 N. Hoffman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Ellis D.T.H.

6 DATE OF BIRTH (month, day, and year) 1877 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43 ~~1~~ ~~78~~	2	13	25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Joseph La.

PARENTS

10 NAME OF FATHER Thos. Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) La

12 MAIDEN NAME OF MOTHER Mary Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) La

14 Informant Mary E. Ellis (Address) 507 N. Hoffman

15 Filed JAN 11 1925 19 QUEEN R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1925

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1924 to Jan. 7, 1925.

that I last saw h in alive on Jan 7, 1925

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... dup

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. T. Hennessy, M. D.

(Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem. DATE OF BURIAL 1/11 1925

20 UNDERTAKER Samuel Hundley ADDRESS 578 N Eddy St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93955

CERTIFICATE OF DEATH.

70-464

Registered No. D 93955

1-PLACE OF DEATH

City of BALTIMORE: (No. 2526 W. Pratt St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Madelener

(a) Residence No. 2526 W Pratt St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Madelener

6-DATE OF BIRTH (month, day and year): May 4 1850

7-AGE: 74 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Leopold Hohenhalz

(Address) 2526 W Pratt

15- Filed JAN 11 1925 192 ROBERT R. KNAUER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jany 10/25

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 19 24 to Jany 10 19 25

that I last saw h[illegible] alive on Jany 9 19 25

and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P. Gustav Dill M. D.

1/10 1925 (Address) 1433 W Lombard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Jan 13 1925

20-UNDERTAKER: Wm Cook

ADDRESS: 1026 Gorsuch Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Spelled EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93956

CERTIFICATE OF DEATH.

B 93956

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 E 22d St.; 9-4 Ward)

2-FULL NAME Laura E. Bell.

(a) RESIDENCE. No. 900 E North Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Wallace Bell

6 DATE OF BIRTH (month, day, and year) Nov 18 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Lewis Chrisman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Virginia Cronan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Raymond Chrisman
(Address) 900 E North Ave

15 Filed JAN 11 1925 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1925, to Jan 9, 1925, that I last saw h~~e~~r alive on Jan 9, 1925, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis & Nephritis (duration) 4 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Lewis Henderson, M. D.

19 (Address) 1714 N Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 12 1925

20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

D 93957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1211 Linden Ave ST., 11-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sivin Peters

(a) RESIDENCE NO. 1211 Linden Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs 9 mos 22 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Winfield Peters

6 DATE OF BIRTH (month, day, and year) Mar. 19, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	84	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER James Sivin

11 BIRTHPLACE OF FATHER (city or town) Belfast Ireland (State or country)

12 MAIDEN NAME OF MOTHER Sarah A. Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant J. Sivin Peters

(Address) Esquimo, Cochran, Md

15 Filed JAN 12 1925 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10, 1925

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1924, to Jan 16, 1925, that I last saw h~~er~~ alive on Jan 10, 1925, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 2 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Pneumonia Terminal

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clark M. D.

(Address) Catrobe Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Jan 12 1925

20 UNDERTAKER Henry McPerkins & Son — ADDRESS Orchard & Calhoun

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93958

CERTIFICATE OF DEATH.

31 D 93958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 Greenwillan St. Moulton Sraggins 17-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 548 Greenwillan St.

(a) RESIDENCE NO. 548 Greenwillan St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Factory Hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Howard Scroggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Millie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. M. Scroggins
(Address) 548 Greenwillan St.

15 Filed JAN 12 1925, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis 8

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Jan. 9, 1925 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., da. In the State yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 12 1925
20 UNDERTAKER John A Toadvine	ADDRESS 1127 Lemmon Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93959

CERTIFICATE OF DEATH.

14-1 100-001

REGISTERED NO. D 93959

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Madison Ave ST., 14-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lehman Brown

(a) RESIDENCE No. 1708 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ump
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Alex. Brown.

11 BIRTHPLACE OF FATHER (city or town) Ga.
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Davis

13 BIRTHPLACE OF MOTHER (city or town) Ga.
(State or country)

14 Informant Alex. Brown
(Address) 1708 Madison Ave

15 Filed ..... 192 ... ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Jan. 12, 1925 (Address) 280 Eutaw Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-12-25 192

20 UNDERTAKER David Easton

ADDRESS 516 W Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93960

CERTIFICATE OF DEATH.

24-199

D 93960

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Belt Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie R.Grieten.

(a) RESIDENCE NO. 1724 Belt Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced (or) WIFE of Joseph Grieten.

6 DATE OF BIRTH (month, day, and year) August, 2, 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	28	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine operator.
(b) General nature of industry, business, or establishment in which employed (or employer) tobacco factory.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Owen F.Feeney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary B.Link.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Owen F.Feeney. (father)
(Address) 1724 Belt Ave.

15 Filed ..... 192 ..... (CLAIR A. KRAUTER) Registrar

JAN 12 1925

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Sepsis.

Self produced abortion.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt (Coroner.) M. D.

Jany. 10, 1925 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stes Crucis Coe.	1/12/25
20 UNDERTAKER	ADDRESS
J. F. Fahey & Son	1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 93961 HEALTH DEPARTMENT—CITY OF BALTIMORE 29 D 93961

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Cedarcroft Rd. St.; 27-1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah C Base

(Residence in Baltimore: No. 413 Cedarcroft Rd. St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 30 (Day), 1844 (Year)

7-AGE, 80 yrs. 6 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home work

9-BIRTHPLACE, (State or Country) Balto. Co.

PARENTS.

10-NAME OF FATHER, Daniel Base

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sarah Guiton

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H Eck

(Address) 413 Cedarcroft Road

15- JAN 12 1925

Filed ....., 191.... ROBERT M. MAGRUDER, Registrar. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 11th (Day), 1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1925, to Jan 11 1925, that I saw h er alive on Jan 11 1925, and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Laryngeal

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) Harold C Gilbertson M. D.

1/11, 1925. (Address) 413 Cedarcroft Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Chestnut Grove Balto — DATE OF BURIAL. 1-14-1925

20-UNDERTAKER William Cook — ADDRESS 502 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93962 — 100-001 — D 93962

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1900 E North St., 8-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frances E. Svec

(a) Residence No. 1900 E North St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 13 1923

7-AGE. 1 yrs. 8 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto.
(State or Country).

PARENTS.

10-NAME OF FATHER. Joseph Svec

11-BIRTHPLACE OF FATHER (city or town) Bohemia
(State or Country).

12-MAIDEN NAME OF MOTHER. Annie Kuta

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country).

14- (Informant) Joseph Svec

(Address) 1900 E North Ave

15- Filed..... 192.... Registrar.

MAR 12 1925

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 10 1925

17- I HEREBY CERTIFY, That I attended deceased from January 9 1925 to January 10 1925, that I last saw him alive on January 10 1925, and that death occurred, on the date stated above, at 1225 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No What test confirmed diagnosis? Clinical Examination

(Signed) Albert L Saufley M. D

1/10/ 1925 (Address) 2027 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Mar 12, 1925

20-UNDERTAKER. Frank Crook Son — ADDRESS 1005 Linden

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAKE SURE THAT A SEAL APPEARS

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93963

CERTIFICATE OF DEATH.

REGISTERED NO. D 93963

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4114 Walnut Av ST., 28-482 WARD)

2-FULL NAME Ida Bell Brittain

(a) RESIDENCE NO. 4114 Walnut Av ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 62 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Saml L. Brittain

6 DATE OF BIRTH (month, day, and year) July 21-1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
62	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry L. Luck

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elvesta Belbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Saml L. Brittain
(Address) 4114 Walnut Av

15 Filed JAN 12 1925 ADOLPH H. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 7, 1925, that I last saw h[illegible] alive on Jan 8, 1925, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Hypertrophic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Olney Myers, M. D.

, 19 (Address) 1517 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan 12 192[illegible]
20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Av

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93964

CERTIFICATE OF DEATH.

D 93964

1-PLACE OF DEATH Sharps. Dept.

Registered No.....

City of BALTIMORE: (No..... St., 9-2 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Marcellus Mitchell Davis

(a) Residence No. Solomons Island Md. St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline V. Davis

6-DATE OF BIRTH (month, day and year) Aug 13, 1858

7-AGE. 66 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Shipbuilder

(b) General nature of indnstry, business, or establishment in which employed (or employer). Self

(c) Name of employer. Cambridge Md.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John T. Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Cornelia Mitchell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mrs Pauline V. Davis

(Address) Solomons Md.

15-

Filed JAN 12 1925 CERT R. [illegible] Burial Permit [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 10-25

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st, 19 24, to Jan 10, 19 25,

that I last saw h.. alive on Jan 10, 19 25,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia & peritonitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 6-25

Was there an autopsy? no. Probably Post Mortem

What test confirmed diagnosis?

(Signed) G. B. Sybert, M. D

, 19 (Address) St Jos. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Druid Ridge Cem	Jan 12, 25
20-UNDERTAKER	**ADDRESS**
Wm J Ricketts Sons	North Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93965

CERTIFICATE OF DEATH.

179 D 93965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth A. Cornell

(a) RESIDENCE No 411 N. Carrollton Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James A. Cornell

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Clara Hynson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Clara Cornell
(Address) 411 N. Carrollton Ave

15 Filed JAN 12 1925 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 192 5

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Body burned, Clothing caught fire Gas Stove (Duration) 6 hrs. yrs. mos. ds. accidental

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)
, 192 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional directions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 12 1925

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93966

CERTIFICATE OF DEATH.

D 93966

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 10-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Kelly.

(a) RESIDENCE NO. 1018 E. Biddle St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. ---- mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (XXXXXXX) Margaret Kelly.

6 DATE OF BIRTH (month, day, and year) Donot know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Marble setter.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

016

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Terrence Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine McKenna.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Margaret M. Ragan.
(Address) 1018 E. Biddle St.

15 Filed JAN 12 1925, 192 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall on the street.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jany. 10, 192 5 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident, Ballsway & Lexington St.

Former or usual residence December 30, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan 13 1925

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93962

CERTIFICATE OF DEATH.

D 93962

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 15-10 WARD)

2-FULL NAME Myrtle Carroll. N.

(a) RESIDENCE NO. 1644 Gilmor st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Chew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgia Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 12 1925 19 THEO. R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10, 1925

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to Jan. 10, 1925, that I last saw her alive on Jan. 10, 1925, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, lab.

(Signed) L. A. White, M. D.

1-10-25 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Zion — Jan 12 1925

20 UNDERTAKER — ADDRESS

Wm. H. Carey Son — 1400 Madison

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93968

CERTIFICATE OF DEATH.

D 93968

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 N. Milton ave St., 7-3 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Emma Pomfritz

(a) Residence No... 725 N. Milton ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Herman Pomfritz

6-DATE OF BIRTH (month, day and year) Oct 3-1850

7-AGE, 75 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer). Home duties
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richter Wilzetheim

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Cath. Crone

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) William Pomfritz

(Address) 725 N. Milton ave

15- Filed JAN 12 1925 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1-8-25

17- I HEREBY CERTIFY, That I attended deceased from 1-3-25 to 1-8-25 19..

that I last saw h.. alive on 1-8-25 19..

and that death occurred on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

..... (Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Syndrome

(Signed) ..... M. D.

1-9, 19.. (Address) 2000 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Jan 12, 1925
20-UNDERTAKER,	ADDRESS
Wm T. Lantzy	815 N. Washington

In order that this certificate may be filled out EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 93969

CERTIFICATE OF DEATH.

155

B 93969

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 623 E. 37th St., 9-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Holt

(a) RESIDENCE No. 623 E 37th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Holt

6 DATE OF BIRTH (month, day, and year): March 1848

7 AGE — Years: 76 — Months: 10 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Michael Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Eliz R Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Mary's Md.

14 Informant: Mrs. Stair

(Address): 623 E 37th St.

15 Filed JAN 12 1925 19 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10th 1925

17 I HEREBY CERTIFY, That I attended deceased from about Jan 1, 1920, to Jan. 10, 1925, that I last saw her alive on Jan 8, 1925, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH was as follows:

Osteitis Deformans

(Paget's Disease)

Chronic (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. L. Preston, M. D.

Jan 11 1925 (Address) 2424 E 33 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: 1-13-1925

20 UNDERTAKER: J. J. Moran

ADDRESS 2000 E Baltimore

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93970

CERTIFICATE OF DEATH.

1-21-08

D 93970

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) Francis T. V. Hospital ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter D. Kunz

(a) RESIDENCE No 1229 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose. A. Kunz

6 DATE OF BIRTH (month, day, and year) Apr 28 / 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Operated Band
(b) General nature of industry, business, or establishment in which employed (or employer) Carriage & Top Co
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Sam Kunz

11 BIRTHPLACE OF FATHER (city or town) Switzerland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Maggie

13 BIRTHPLACE OF MOTHER (city or town) Switzerland
(State or country)

14 Informant Sam Kunz
(Address) 1229 Cleveland St

15 Filed JAN 12 1925, 192 ... Registrar
Special Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 - 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Jan 11 1925 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional instructions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan. 12 1925
20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son	ADDRESS 801 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93971

CERTIFICATE OF DEATH.

D 93971

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4609 Culver Ave. Laurayille ST., WARD)

2-FULL NAME Lillian Anna O'Kelly

1a) RESIDENCE No. 4609 Culver ave. Laurayille ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Claud M. O'Kelly

11 BIRTHPLACE OF FATHER (city or town) Durham Co.
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ruth Little

13 BIRTHPLACE OF MOTHER (city or town) York
(State or country) Pennsylvania

14 Informant Claud M. O'Kelly
(Address) 4609 Culver Ave Laurelle

15 Filed JAN 12 1925, 19 ROBERT A. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1925 to Jan 11 1925.

that I last saw h... alive on 19

and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions uncl.
Meningismus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza &
Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claud Smith, M. D.

1/11, 19 25 (Address) 4 102 Harpoda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cmetery — DATE OF BURIAL Jan 12 1925

20 UNDERTAKER Fred K Leasman Sons — ADDRESS Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. H. A. Kuell

1924
20
1925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93972

CERTIFICATE OF DEATH.

Registered No. D 93972

1-PLACE OF DEATH

City of BALTIMORE (No. 325 S Bolling St., 20-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna F. Klein

(a) Residence No. 325 S Bolling and St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced (HUSBAND OF WIFE) Joseph F. Klein

6-DATE OF BIRTH (month, day and year) Nov 23rd 1904

7-AGE 20 yrs. 1 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country) Baltimore Md

PARENTS

10-NAME OF FATHER Albert Zellenbach

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Italy

12-MAIDEN NAME OF MOTHER Lena Schaefer

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Baltimore Md

14- (Informant) Joseph F. Klein

(Address) 325 S Bolling Ave

15-

Filed JUN 12 1925 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 11-25

I HEREBY CERTIFY, That I attended deceased from Dec 20 1925 to Jan 11 1925

that I last saw h[illegible] alive on Jan 10 1925

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) W. A. Kuell M. D.

1/11 1925 (Address) 4207 Forest Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Cemetery

DATE OF BURIAL, Jan 13 1925

20-UNDERTAKER

ADDRESS

115 Highland 1854 W Balto St

Shall be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Howie

Spec.—6-9-19—H. P. Co.—1000 Bks.

93973 HEALTH DEPARTMENT—CITY OF BALTIMORE 93973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2519 Hollins ST.: 70-4 WARD) REGISTERED NO. 58-80

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Howie

(a) RESIDENCE. NO. 2519 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 2 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Howie

6 DATE OF BIRTH (month, day, and year) May 4 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Clay Main

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Julia Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Robt M Howie
(Address) 2519 Hollins

JAN 12 1925 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924 to Jan 9, 1925 that I last saw h relive on Jan 9, 1925 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia (duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Epithelioma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed H. C. Campbell M. D.

(Address) 1644 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 12 1925

20 UNDERTAKER F. B. Neppert ADDRESS 1850 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93974

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital WARD) 13-6

2-FULL NAME Frank G. Weber Jr.

(a) RESIDENCE NO. 2409 Lakeview Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 27, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank G. Weber.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Summerfield.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14
Informant Mary Weber.(mother)
(Address) 2409 Lakeview Ave.

15
Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10, 1925. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary) (duration) ... yrs. ... mos ... da.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

Jany. 10, 1925 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
2409 Lakeview Ave.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Jan 12 1925

20 UNDERTAKER: L. Sander Sons — ADDRESS: 1710 Reed St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—3-10-21—M&T—1500 Blks.

D 93975 HEALTH DEPARTMENT—CITY OF BALTIMORE D 93975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO. 80

CITY OF BALTIMORE: (No. Lombard & Greene Sts. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Boile Engeser

(a) RESIDENCE NO. Linwood, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Windsor Md.

PARENTS

10 NAME OF FATHER Mr Jerry Boile

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Windsor Md.

12 MAIDEN NAME OF MOTHER Lucie Englar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Milford Md.

14 Informant (Address) University Hospital London St & Greene Sts

15 Filed Oct 23, 1924 J. Edward West Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1924, to Oct 22, 1924

that I last saw her alive on Oct 22, 1924,

and that death occurred, on the date stated above, at 8 am

The CAUSE OF DEATH* was as follows:

Carcinoma of lungs

May 19 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. Norman Walker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pipe Creek — DATE OF BURIAL Oct 25, 1924

20 UNDERTAKER L. H. Weimer. — ADDRESS New Windsor

ROBERT N. KRAUTER,

PRINT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 93976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Washington ST., 7-2 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred A. Reist

(a) RESIDENCE NO. 519 N. Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 14 18

7 AGE — Years: 6 — Months: 4 — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Harry R. Reist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Alma M. Burgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Harry R. Reist
(Address) 519 N. Washington

15 Filed JAN 12 1925 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1924, to Jan 11, 1925, that I last saw h[illegible] alive on Jan 11, 1925, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Diphtheria

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Alma B Lennard, M. D.

1/14 19 25 Address 1825 Pax Pkwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 1/14 1925

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Aliceanna

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93977

76-6 199

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 47 S. 11th ST., WARD)

2-FULL NAME Catherine Hill

(a) RESIDENCE No 47 S. 11th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Hill

6 DATE OF BIRTH (month, day, and year) Nov 21 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sparrows Point Md

PARENTS

10 NAME OF FATHER John McNicholis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Walter Hill
(Address) 47 S. 11th St

15 Filed JAN 12 1925 ROBERT R. KRAUTER, Registrar

Burial Permit (over)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia
(General Peritonitis)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Self Induced Abortion

(duration) yrs. mos. 4 ds.

(Signed) James M Benson, M. D.
(Coroner.)

Jan 12. 1926 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 1/13 1925

20 UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93978

CERTIFICATE OF DEATH.

57 D 93978

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2603 Jefferson ST., 63 WARD)

2-FULL NAME Wilhelmina Eikenberg

(a) RESIDENCE NO. 2608 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: George Eikenberg

6 DATE OF BIRTH (month, day, and year): May 31, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. David Padgett

(Address): 2709 Eastfield Ave

15 Filed JAN 12 1925 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9th 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1924 to Jan 9, 1925

that I last saw her alive on Jan 9, 1925

and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fehlings sugar test

(Signed) H. L. Reinhold, M. D.

(Address) 5100 Allendale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenlief Cemetery — DATE OF BURIAL: 1/12/25

20 UNDERTAKER: Geo. Weber & Son — ADDRESS: 2503 Edmondson

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 93979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 188-009

D 93979

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) University Hospital ST., 16-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lynn Frances Gruber

(a) RESIDENCE NO Westminster md ST., 3110 Baker St (Life) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Benjamin F. Gruber

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Mattie B. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Benjamin F. Gruber
(Address) 3110 Baker St

15 Filed JAN 12 1925, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Internal injuries

(duration) ....yrs. a few hrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) on sled & ran into automobile

(duration) ....yrs. ....mos. ....ds.

(Signed) H K Gorman, M. D.
(Coroner.)

1-12, 1925 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 1/13/25, 192

20 UNDERTAKER Chas. Weber & Son — ADDRESS 2533 Edmonson

DEATH is very important. See instructions on back of certificate.
that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93980

CERTIFICATE OF DEATH.

D 93980

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sutton Station Colgate Creek St.) 16-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sophia W. Robinson

(a) RESIDENCE. No. Sutton Station Colgate Creek St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Robinson

6 DATE OF BIRTH (month, day, and year) July 26-1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis Doll

11 BIRTHPLACE OF FATHER (city or town) Cincinnatti (State or country) Ohio

12 MAIDEN NAME OF MOTHER Dach.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Louise E. Robinson (Address) Annapolis Md.

15 Filed JAN 12 1925 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Jan 10, 1925, that I last saw her alive on Jan 9, 1925, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Asst Reier, M. D.

1925. 19 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Jan 13 1925

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 93980

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93981

CERTIFICATE OF DEATH.

16-5129

D 93981

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 N. Monroe ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hasey R. Mitten

(a) RESIDENCE NO. 601 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
69	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Augustus Mitten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carrollton Md

12 MAIDEN NAME OF MOTHER Margaret Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Md

14

Informant Jennie Mitten

(Address) 601 N. Monroe St

15 Filed JAN 12 1925 ROBERT J. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11- 1925-

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23- 1924, to Jan. 11- 1925-;

that I last saw ~~him~~ alive on Jan. 10- 1925-;

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) about yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Gross & microscopic

(Signed) Chas. L. McCarthy M. D.

. 19 (Address) 2410 E. Monument Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 14 1925
20 UNDERTAKER George J. Sawicki	ADDRESS 1532 Hollins St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 93982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93982

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Harten

(a) RESIDENCE NO. Wilkens & Whitmore Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, or ~~Divorced,~~ (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Harten

6 DATE OF BIRTH (month, day, and year) Nov 23 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Frank Harten (Address) 2228 Riggs Ave

15 Filed JAN 12 1925 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10 1925

17

I HEREBY CERTIFY, That I attended deceased from Dec. 30th, 1924, to Jan. 10th, 1925, that I last saw him alive on Jan 10th, 1925, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Pt: Hemiplegia

Senile Arteriosclerosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W Deans, M. D.

, 1924 (Address) 504 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Jan 13 1925

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mallonee

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93983

CERTIFICATE OF DEATH. 1161-001 D 93983

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 25-11 WARD)

2-FULL NAME Baby Boy Mallonee

(a) RESIDENCE No. 211 Church St. WARD Govans Boro Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10 - 25 at 4.20 P m

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James J Mallonee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Moerle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record

(Address) .....

15 Filed JAN 12 1925 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10/25

17

I HEREBY CERTIFY, That I attended deceased from 1/10/25, 19.... to 1/10/25, 19....

that I last saw it alive on 1/10/25, 19.... and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....

.....

.....

.....

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? J

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) K. W. Talley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. A. Co. DATE OF BURIAL Jan. 12 1925

20 UNDERTAKER Margaret J. Flynn ADDRESS 1417 Light St

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 93984

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1302 Mc Culloh St., 11-10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Harry Hall

(Residence in Baltimore: No. 1302 Mc Culloh St.; 20 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH. Dec. 7, 1904
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
20 yrs. 1 mos. 2 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... General

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Harry Hall

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Mamie Brooks

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Hall

(Address) 1302 Mc Culloh St.

15- Filed JAN 12 1925 ROBERT A. ROBERTS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 9, 1925
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Jan. 10, 1925 (Address) 2902 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Zion Cem.	Jan 12, 1925

20-UNDERTAKER.	ADDRESS
for Chas a Ferrell	2319 Druid

Spec—12-23-21—E.B.R.S.—400 Eks.

Stedtler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93985

CERTIFICATE OF DEATH.

49 D 93985

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., 9-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Louis Stedtler.

(a) Residence No. 3201 Trinity Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia B. Stedtler

6-DATE OF BIRTH (month, day and year) Nov. 5, 1872

7-AGE 51 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer. 09

(b) General nature of industry, business, or establishment in which employed (or employer) Packer Hams

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS

10-NAME OF FATHER, Charles Stedtler

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Maggie Neuninger

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

11- (Informant) Sophia B. Stedtler

(Address) 3201 Trinity St.

15-

Filed ..... 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 9, 1925

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 ..., 19 24 to Jan 9 ..., 19 25

that I last saw h.. alive on Jan 9 ..., 19 25

and that death occurred, on the date stated above, at 8.45 m.

The CAUSE OF DEATH* was as follows:

Mediastinal Tumor - (Sarcoma?)

Supposed tumor of

(Duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Biopsy.

(Signed) A. Gustin Pearre M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery DATE OF BURIAL 1/12 19 25

20-UNDERTAKER, Chas. B. Ames & Son ADDRESS 11 E Mt Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

Johenning

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93986

CERTIFICATE OF DEATH.

D 93986

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 40-3 St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Johenny

(a) RESIDENCE NO. 2722 Eden Ave. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Johenning Sr

6 DATE OF BIRTH (month, day, and year) Apl 9-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Gilchrist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cecelia Flanigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mercy Hospital

15 Filed ....., 19 ..... Registrar

JAN 12 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11/25 19

17 at 4 p.m.

I HEREBY CERTIFY, That I attended deceased from 1/10/25, 19..... to 1/11/25, 19.....

that I last saw her alive on 1/11/25, 19

and that death occurred, on the date stated above, at 8 20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Gilley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 14 1925

20 UNDERTAKER Chas. P. Graul & Son ADDRESS 118 W. Mt. Royal ave

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93987

Registered No. 90 163

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 N. East Ave. St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Nels Schmidt

(a) Residence No. 27 N. East Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Schmidt.

6-DATE OF BIRTH (month, day and year) April 2-1854

7-AGE. 70 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) American Tobacco Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Denmark.

PARENTS.

10-NAME OF FATHER, Peter Schmidt.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Denmark.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Denmark

14- (Informant) Hilda Schmidt.

(Address) 27 N. East Ave.

15- Filed JAN 12 1925 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 9th 1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1925 to Jan 9 1925

that I last saw h alive on Jan 9 1925

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute - Nephritis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Albuminuria

(Signed) John S. Owens M. D.

Jan 10, 1925 (Address) 35 N. Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL, Jan. 12 1925

20-UNDERTAKER. Lilly & Zile ADDRESS 403 S. Wolfe St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 93988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4616 Elrode ave ST., W. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry W. Lauman Sr

(a) RESIDENCE No. 4616 Elrode ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Annie Lauman

6 DATE OF BIRTH (month, day, and year): Jany 28 1867

7 AGE: Years 57 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supr Miller Co

(b) General nature of industry, business, or establishment in which employed (or employer): See 486

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Adam Lauman Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Dammeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry W Lauman Jr

(Address) 4616 Elrode ave

15 Filed ....., 19 .....

Registrar

JAN 12 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 10 1925

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to Jan 10, 1925.

that I last saw h alive on Jan 10, 1925.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of the liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion + Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

19 24 (Address) 476 Harpst ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Smith Cemetery

DATE OF BURIAL: Jany 13 1925

20 UNDERTAKER: Roth & Sons

ADDRESS: 1 X X 2 W Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Jankunas

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93989

D 93989

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 10-2 WARD)

2-FULL NAME Helen Jankunas

(a) RESIDENCE NO. 2800 Anson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Andrew Sonent

11 BIRTHPLACE OF FATHER (city or town) Lith. (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Lith (State or country)

14 Informant Municipal Hospital (Address)

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9 1925

17

I HEREBY CERTIFY, That I attended deceased from 12-13, 1924 to 1-9, 1925

that I last saw her alive on 1-9, 1925

and that death occurred, on the date stated above, at 6^10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Korsakoff Syndrome

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Aut.

(Signed) Chas. G. Drew M. D.

1-11. 1925 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Jan 14 1925
20 UNDERTAKER	ADDRESS
Mary Grebinickas	426 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 93990

Registered No.

1-PLACE OF DEATH

City of BALTIMORE (No. 811 Preach al (rear) St. 22 Ward) 1/2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isaac Harris

(a) Residence No. 811 Preach al (rear) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. Col.

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (~~Write the word.~~) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer). General

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) Mary Hardin

(Address) 906 Leadenhall

15-

Filed JAN 12 1925 1925 R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/9/25

17- I HEREBY CERTIFY, That I attended deceased from 1/7/ 1925 to 1/9/ 1925

that I last saw h alive on 1/9/ 1925

and that death occurred, on the date stated above, at 10-08 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Thos Bartley M. D.

1/12/25 1925 (Address) 908 Shark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. National Cemetry — DATE OF BURIAL. Jan 12 1925

20-UNDERTAKER. R L Parham — ADDRESS 906 Leadenhall St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93991

CERTIFICATE OF DEATH.

D 9399

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2365-3rd, ST., 16-590 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give NAME instead of street number and fill out No. 18.)

2-FULL NAME Aloysius Siewierski

(a) RESIDENCE No 236-3rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? 32 yrs. mos. d

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia Siewierski,

6 DATE OF BIRTH (month, day, and year) November 28. 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	I	I2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoe maker,
(b) General nature of industry, business, or establishment in which employed (or employer) at home,
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Matthew Siewierski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Katherine Nowicki,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Julia Siewierski, (Wife)
(Address) 236 So. Third Street

15 Filed JAN 12 1925 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9- 192

17 I HEREBY CERTIFY, That I took charge of remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her d on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. d.

CONTRIBUTORY (Secondary) Broken Compression

(duration) 2 yrs. mos. 1 ds.

(Signed) G C Slade, M. D.
(Coroner.)
Jan 11th 192 (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy-Rosary Cemetery	Jan. I3- 192 5
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

D 93992

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 93992

Registered No. C.....

City of BALTIMORE: (No. Maryland General Hospital St. 11-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F. Shinnamon Jr.

(Residence in Baltimore: No. Maryland General Hospital St.; yrs. ..... mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. January 5 (Month) (Day) 1923 (Year)

7-AGE.	If LESS than 1 day,
2 yrs. 4 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Elkridge Maryland

PARENTS.

10-NAME OF FATHER. George F. Shinnamon Sr.

11-BIRTHPLACE OF FATHER, (State or Country). Elkridge, Maryland

12-MAIDEN NAME OF MOTHER, Anna May Lauer

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Geo. F. Shinnamon Jr. (Informant)
Elkridge, Maryland (Address)

15-
Filed ..... 192.....
ROBERT R. KRAUTER, Registrar.
JAN 12 1925 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9th 5 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

1-10 192 5 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Elkridge, Maryland

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Melvin Cemetery	Jan 12 1925

20-UNDERTAKER. Jos Brook Elkridge ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

Wagner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93983

CERTIFICATE OF DEATH.

24-3 29

D 93998

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 E Fort Ave. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wagner

(a) RESIDENCE NO. 1606 E. Fort ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wagner

6 DATE OF BIRTH (month, day, and year) June 15, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry G. Wagner

(Address) 1606 E Fort ave

15 Filed JAN 12 1925, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1925, to Jan 10, 1925.

that I last saw him alive on Jan 9, 1925.

and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos Fa Stevens M. D.

1/10, 1925 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 17 1925

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93994

CERTIFICATE OF DEATH.

1834-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 120 S.Addison St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William G.Kirmess,

(a) Residence No.....120 S.Addison St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline J.Kirmess,

6-DATE OF BIRTH (month, day and year) Oct.26.1847

7-AGE,	If LESS than 1 day,
78 yrs. 2 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wm.G.Kirmess,

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Augusta Ziminger.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)..... Pauline G.Kirmess.

(Address)..... 120 S.Addison St

15- Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

JAN 12 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) JAN 10 1925

17- I HEREBY CERTIFY, That I attended deceased from January 10 1925 to ..... 19.....

that I last saw h.. alive on January 10 1925,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

.....(Duration)....? yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Chronic cystitis

.....(Duration).....yrs.....mos....1....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Wm Vollmer, M. D.

JAN 11 1925, 19 (Address) 52 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Western	JAN 13 1925, 19....

20-UNDERTAKER,	ADDRESS
Geo W Little	1708 EDMONDSON AVE.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 93995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15-129

D 93995 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 39 Cold Spring Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Baker,

(a) Residence No. 1829 Clifton Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Elijah Baker.

6-DATE OF BIRTH (month, day and year) July 22, 1855

7-AGE. 69 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Patrick Mc Gee

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Annie Kenneday,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14- (Informant): Elijah Baker,

(Address): 1829 Clifton Ave,

15- Filed ..... 192.. ELLA B. KRAUTER, Registrar.

~~Issued Certificate Copy~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) JAN 10 1925

17- I HEREBY CERTIFY, That I attended deceased from June 1 25, 1920, to January 10 25, 1925, that I last saw h. alive on January 10 25, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 3 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? 1829 Clifton Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Urinalysis

(Signed) Wm J Sumwalt, M. D.

1411 1925 (Address) 1701 W. Lafayette Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~, Loudon Park — DATE OF BURIAL JAN 13 1925, 19....

20-UNDERTAKER, Geo W Little — ADDRESS 2700 EDMONDSON AVE.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 93996

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 93[illegible]

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 McCulloh St St., 14-1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Crime Laws

(a) Residence No. 1424 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 24-1893

7-AGE, 31 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Wyomissing Pa

PARENTS

10-NAME OF FATHER Wm T. Barclay

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ind

12-MAIDEN NAME OF MOTHER, Victoria Conway

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ind

14- (Informant) Mary Barclay

(Address) 1424 McCulloh

15-

Filed ..... 192.....

JAN 12 1925

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 11-1925

17- I HEREBY CERTIFY, That I attended deceased from December 30 1924 to Jan. 11 1925

that I last saw her alive on January 10 1925

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) 9 yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. 9 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. W. Kennard M. D

1-12 1925 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL. Cemetery Ind 1-13 1925

20-UNDERTAKER, Helen A. Holland ADDRESS 1631 Orleans Baltimore

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 9399 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 93997.

CERTIFICATE OF DEATH. + 199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital V1-V WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Robinson

(a) RESIDENCE NO. Spring Grove Hospital, Maryland WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married (?)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	20	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Practical Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Spring Grove Hospital
(c) Name of employer Spring Grove, Md.

9 BIRTHPLACE (city or town) Williamsburg, W. Va.
(State or country)

PARENTS

10 NAME OF FATHER William Breen

11 BIRTHPLACE OF FATHER (city or town) Williamsburg
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Hattie Johnston

13 BIRTHPLACE OF MOTHER (city or town) Williamsburg
(State or country) W. Va.

14 Informant Mrs. Mary Robinson
(Address) Spring Grove, Md

15 Filed JAN 12 1925 19 ROBERT R. KRAUSER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 11 — 19 25

17 I HEREBY CERTIFY, That I attended deceased from 1-7-, 1925, to 1-11-, 1925, that I last saw her alive on 1-11-, 1925, and that death occurred, on the date stated above, at 8 35 a. m.

The CAUSE OF DEATH* was as follows:
General Peritonitis following an incomplete, self-induced abortion of 3 mo. gestation.

(duration) ... yrs. ... mos 6 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of 1-8-25
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Jno. A. Tompkins, M. D.
, 19 (Address) M St Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williamsburg Va

DATE OF BURIAL 1-12 1925

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Walbrook

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT ARCHIVES

Spec—12-23-21—E.B.R.S.—400 Pks.

D 93998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93998

CERTIFICATE OF DEATH.

Dr. Snyder

44

1-PLACE OF DEATH

City of BALTIMORE: (No. 746 N. Gay St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Metz

(a) Residence No. 746 N. Gay St., 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: Widow (Write the word.)

5a-If married, widowed, or divorced: HUSBAND of (or) WIFE of the late George Metz

6-DATE OF BIRTH (month, day and year): Oct 9th 1849

7-AGE: 75 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:
10-NAME OF FATHER: Ludwig Price
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Dont Know
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-Informant: Robert L. Donaldson
Address: 746 N. Gay St.

15-Filed 1925
Robert P. Harrison, Registrar.
Burial Permit Clerk.

N 12 1925

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 10th 1925

17-I HEREBY CERTIFY, That I attended deceased from Oct 10 1924 to Jan 10 1925

that I last saw h.. alive on Jan 9 1925

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulm Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cancer of Stomach

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Snyder M. D

1/12, 1925 (Address) 3832 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Jan 13th 1925

20-UNDERTAKER: Lilly & Geier — ADDRESS: 1033 S. Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1506 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93999

CERTIFICATE OF DEATH.

B-33

D 93999

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal tuberculosis Hospital ST. (WARD)

2-FULL NAME Richard Donnelly

(a) RESIDENCE NO. 1415 Eastern ave. ST. 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865 Dec. 25th

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 years		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER James Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Maria Nightengale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant: Hospital Records (Address) M.T.H.

15 JAN 12 1925 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10th 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9 , 1925 , to Jan. , 1925 ,

that I last saw him alive on Jan. , 1925 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. findings

(Signed) J. D. White, M. D.

1/10 1925 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Patricks Cemetery DATE OF BURIAL: Jan. 13 1925

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe

Burial Permit Clerk.

K. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 94000 HEALTH DEPARTMENT—CITY OF BALTIMORE D 94000

CERTIFICATE OF DEATH.

27-4-89

1-PLACE OF DEATH

City of BALTIMORE: (No. 5314 Winner Avenue St., Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John William H. DeMuth

(a) Residence No.....5314 Winner Avenue.....St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ella G.DeMuth

6-DATE OF BIRTH (month, day and year) Oct.11,1868

7-AGE. 56 yrs. 2 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... Contractor for self

9-BIRTHPLACE (city or town) Owings Mills
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Henry W. DeMuth

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER. Mary A. Tase

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pennsylvania

14- (Informant). Mrs. Ella G.DeMuth

(Address)...5314 Winner Avenue.....

15- Filed JAN 12 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan.10,1925

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1925, to Jan 10, 1925, that I last saw h.m alive on Jan 5, 1925, and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Chas. J. Wells, M. D.

1-10, 1925 Address Park Heights Ave. & Belvedere Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Pleasant Owings Mills	Jan 13, 1925
20-UNDERTAKER.	ADDRESS
Jos B. Cook	1003 W Balto St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 9400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9400

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1033 N. Eutaw ST. 11-1 (WARD)

2-FULL NAME Simon P. Perkins

(a) RESIDENCE. No. 1033 N. Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Perkins

6 DATE OF BIRTH (month, day, and year) Nov 2 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
81	81	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Washington Co Maryland

PARENTS

10 NAME OF FATHER Peter Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ida F Evans (Address) 1033 N Eutaw St

15 Filed Robert P. Harrison, Registrar

N 12 1925

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1925, to Jan 10th, 1925, that I last saw him alive on Jan 9th, 1925, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Artero-Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lynd D Grant Scott, M. D.

, 19 (Address) 334 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Garland Hartsville Md	1/13 1925
20 UNDERTAKER	ADDRESS
J Frow Hall	753 Dolphin

*. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 94002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Payson ST.; 16 WARD)

REGISTERED NO. C 161

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME None - Baby Brown

(Residence in Baltimore: No. 706 N. Payson St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, ... Jan 11 ....., 1925
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 5 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 706 N Payson

PARENTS.

10-NAME OF FATHER, Lee Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rose Scott.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Brown

(Address) 706 N. Payson

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

N 1 21925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 12 ....., 1925
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1925, to Jan 11 1925, that I saw her alive on Jan 11 1925, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

..... Premature Birth .....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar E. Hayes M. D.

Jan 12, 1925 (Address) 1500 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Jan 13, 1925
20-UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Pa.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 94003

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 94003

1 PLACE OF DEATH — REGISTERED NO. C 179

CITY OF BALTIMORE: (No. 1817 Dukeland St.; 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Joseph Hunt

(Residence in Baltimore: No. 1817 Dukeland St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: June (Month) 1 (Day) 1846 (Year)

7-AGE: 78 yrs. 9 mos. 9 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Henry Hunt

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Hannah Jones

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Rose Pigott

(Address): 1817 Dukeland

15- JAN 12 1925 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 10th (Day), 1925 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 8th, 1925, to Jan 10th 1925, that I saw h-im alive on Jan. 10th 1925, and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows: Chronic Parenchymatous Nephritis

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY): Uremia

(Duration) yrs. 6 mos. ds.

(Signed) Frank L. Heiss M. D.

Jan 12 1925 [Address] 1838 Edmondson Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Leuden Park Cem — DATE OF BURIAL: Jan 13 1925

20-UNDERTAKER: Jos Jacobs Son — ADDRESS: 217 S. Broa

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D 94004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94004

CERTIFICATE OF DEATH.

REGISTERED NO. 27-431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5316 Wrenn ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline H. Deippel

(a) RESIDENCE No. 5316 Wrenn av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Not for Ops

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Jno L. Deippel

11 BIRTHPLACE OF FATHER (city or town) Ger (State or country)

12 MAIDEN NAME OF MOTHER Barbara Schlotthauer

13 BIRTHPLACE OF MOTHER (city or town) Ger (State or country)

14 Informant W. Deippel (Address) 5316 Wrenn ave

15 Filed JUN 12 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11 1925

17

I HEREBY CERTIFY, That I attended deceased from Jany 7th, 1925, to Jany 11th, 1925, that I last saw her alive on Jany 11th, 1925 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe & Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Old T. B of Lungs (duration) yrs. mos. ds.

18 Where was disease contracted Old chronic case If not at place of death? Was Delicate 6 yrs

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Visible

(Signed) Cahill, M. D.

(Address) 1605 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D. Pauls. Woodlawn DATE OF BURIAL Jan 13 1925

20 UNDERTAKER George L. Schwab ADDRESS 1200 Eutaw Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 94005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 94005

1-PLACE OF DEATH

City of BALTIMORE. (No. 1914 Patterson Pk. St., 8-1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Mac Leary

(a) Residence No. 1914 Patterson Pl. St., ... Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret MacLeary

6-DATE OF BIRTH (month, day and year) Dec 22 1886

7-AGE. 39 yrs. — mos. 19 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer) J. W. Bond

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER Robt MacLeary.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Louise Swope

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto.

11- (Informant) Mary E. MacLeary

(Address) 1914 Patterson Pl.

15- Filed JAN 12 1925 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 19 25

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 19 25 to Jan 19 19 25

that I last saw h.. alive on Jan 19 19 25

and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Ia Grippe

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bron Co Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Evidence

(Signed) Fred Duffy M. D.

Jan 20 19 25 (Address) 80 S. Watt Pk. Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL, Jan 14, 1925

20-UNDERTAKER. Leo A. Wiedefeld

ADDRESS 501 E 22nd St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 94006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94006

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Byrd St. ST., 24-2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle C Barnes

(a) RESIDENCE No. 1526 Byrd, ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Barnes.

6 DATE OF BIRTH (month, day, and year) Oct 10 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	61.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Isaac Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Caroline Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Louis Barnes. (Address) 1526 Byrd St

15 Filed JAN 12 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10 1925.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1925, to Jan 10, 1925, that I last saw her alive on Jan 10, 1925, and that death occurred, on the date stated above, at 30 P m.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ground

(Signed) L F Harrison, M. D.

1925 (Address) 16 Rondall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedarhill. DATE OF BURIAL Jan 14, 25

20 UNDERTAKER W W Cook ADDRESS 502 E North

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 94007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94007

CERTIFICATE OF DEATH.

119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 Druid Blvd ST., 21-3 WARD)

2-FULL NAME Samuel Kenedy Andrews

(a) RESIDENCE NO. 845 Druid Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER J. B. Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charlotte Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary K. Karie

(Address) 845 Washington Blvd

15 Filed JAN 12 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-11 1925

17

I HEREBY CERTIFY, That I attended deceased from 1-4, 1925, to 1-11, 1925.

that I last saw him alive on 1-11, 1925,

and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 9 yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Focal Infection

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dunn M. D.

, 19 (Address) 1127 Druid Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Jan 15 1925

20 UNDERTAKER Wm Cook ADDRESS 302 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Grosfoms, 3100 Harford Road ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94008

CERTIFICATE OF DEATH.

D 94008

57

8-1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Cliftview Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Mukins

(a) RESIDENCE NO. 1614 Cliftview Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia M Mukins

6 DATE OF BIRTH (month, day, and year) Oct 24 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Mukins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emily Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Julia M Mukins

(Address) 1619 Cliftview Ave.

15 Filed JAN 12 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1925

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 10, 1925

that I last saw h/M alive on Jan 9, 1925

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) Cus yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cushman, M. D.

Jan 11 1925 (Address) 3100 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 13 1925
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

PREPARED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Dr Dudley, 1829 E Belt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94009

CERTIFICATE OF DEATH.

D 94009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1916 Aliceanna (St.) V (Ward) 2

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B Lehner

(a) RESIDENCE (Usual place of abode) No. 1916 Aliceanna St., Ward

Length of residence in city or town where death occurred 1/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A Lehner

6 DATE OF BIRTH (month, day, and year) June 1. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General Labor 040

(c) Name of employer Fisher

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth A Lehner

(Address) 1916 Aliceanna St

15 Filed JAN 12 1925, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1925, to Jan 10, 1925, that I last saw him alive on Jan 10, 1925, and that death occurred, on the date stated above, at 12:20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Diabetes Various ulcers

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Kemp Dudley, M. D.

Jan 11, 1925 (Address) 2938 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Jan 15 1925

20 UNDERTAKER Wm Cook — ADDRESS 528 Light St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94010

D 94010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 10 E. York St., 2216 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Lombardi

(a) Residence No. 10 York St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1/11-25

7-AGE. ....yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS

10-NAME OF FATHER, Giovanni Lombardi

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Solinda Rotoli

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Giovanni Lombardi

(Address) 10 York St.

15- Filed ... 19... Robert P. Harrison, Registrar.

JAN 12 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-12-25

17- I HEREBY CERTIFY, That I attended deceased from 1-11-25 to 1-12-25

that I last saw him alive on 1-11-25

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows: Premature birth 6/12 [illegible]

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Durando M. D.

1-12, 1925 (Address) 1004 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents Cemty

DATE OF BURIAL. Jan 13 1925

20-UNDERTAKER, Wm J Kuth

ADDRESS 1738 Harford Ave

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

(Anna B. Hooper)

D 9401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9401

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 520 Brun ST., 17-3 WARD. REGISTERED No. 141

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B Hooper

(a) RESIDENCE. No. 520 Brun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Saml Hooper Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Boyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant (Address) Saml Hooper 520 Brunt St

15 Filed JAN 12 1925, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 1925

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1925, to June 9, 1925, that I last saw h e alive on June 9, 1925, and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pressure Dysphoria Lues of the Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of —

Was there an autopsy? N

What test confirmed diagnosis? Clinical

(Signed) H K Turnbull, M. D.

1-11-1925 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 13 1925

20 UNDERTAKER John H. Jordan ADDRESS 1105 Hanover ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

(Laura L. Harris)

D 94012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94012

CERTIFICATE OF DEATH.

162

REGISTERED NO. 248

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 621 Hartsdale ST., 22-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Corine Harris

(a) RESIDENCE NO. 621 Hartsdale ST., 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Rosella Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Colorado U.S.

14 Informant Rosella Harris

(Address) 621 Hartsdale

15 Filed JAN 12 1925, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11 1925

17 I HEREBY CERTIFY, That I attended deceased from 1/11, 19 25, to 1/11, 19 25, that I last saw h[illegible] alive on 1/11, 19 25, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pyuria and Hematuria

Stage of Dropping of Kidney.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

5 hours (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. M. Barker, M. D.

1/12, 19 25 (Address) 709 Hartsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 13 1925

20 UNDERTAKER John N. Tradin — ADDRESS 1027 Hartsdale

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—

Spec—12-23-21—E.B.R.S.—400 Blks.

D 94013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94013

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

City of BALTIMORE: (No. Woman's Hospital St. 12-3 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate C. Spamer

(a) Residence No. 2510 Maryland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ?

7-AGE.	If LESS than 1 day.
68 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Christian Spamer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Eliz. M. Schroeder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs. Drew P. Spamer

(Address) 2317 N. Charles St.

JAN 13 1925 ASHLEY S. KRAUT Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 11/25

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1925 to Jan 11, 1925, that I last saw h.er alive on Jan 11, 1925, and that death occurred, on the date stated above, at 7.25 A. m.

The CAUSE OF DEATH* was as follows:

Splenomegaly

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 1-9-25

Was there an autopsy? Yes

What test confirmed diagnosis? Enlarged Spleen

(Signed) Frederick A. Sinpler, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem.	13, 1925
20-UNDERTAKER,	ADDRESS
Chas. Ortwein & Sons	1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94014

CERTIFICATE OF DEATH.

74-001

D 94014

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1624 Latrobe ST., 12-6 WARD)

2-FULL NAME George Bowman

(a) RESIDENCE NO 1624 Latrobe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dent Bowman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Bowman
(Address) 1624 Latrobe

15 Filed JAN 13 1925 194 ROSE A. KRAUTER, Registrar
Burial Permit Issued
THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Kelly, M. D.
(Coroner.)

Jan 11, 1925 (Address) 1089 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 14 1925
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	Fairfield

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 94015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 Barclay St. ST., 12-6 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Newsome

(a) RESIDENCE No. 1331 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Newsome

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40 about			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Jas. Newsome

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER A. Eborton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mrs. Newsome
(Address) 1331 Barclay

15 Filed JAN 13 1925 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

(Signed) W. J. Riley, M. D.
(Coroner.)

Jan 11, 1925 (Address) 1639 Bradley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Jan 14 1925

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS Baltimore

THE MORGUE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D94016. HEALTH DEPARTMENT—CITY OF BALTIMORE D94016.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1153 Riverside ST. 24-19 WARD)

REGISTERED NO. 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L Hood

(a) RESIDENCE NO. 1153 Riverside ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William R Hood.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Alice Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant William R Hood

(Address) 1153 Riverside Ave

15 Filed JAN 13 1925, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 12. 1925

17

I HEREBY CERTIFY, That I attended deceased from 1. 2. 25. , 19 .... to 1. 12. , 1925.

that I last saw h[illegible] alive on 1. 11 , 19 25

and that death occurred, on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. .... mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? none Physical Exam,

What test confirmed diagnosis?

(Signed) Edward Norris M. D.

1. 13 , 19 25 (Address) 107 E West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem	Jan 13, 1925

20 UNDERTAKER ADDRESS

A. Leonard Evans 35 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—REMOVED FOR BURNING

Spec—12-23-21—E.B.R.S.—400 Blks.

94017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+38 D 94017

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph's Hospital St., 9-7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Liveris

(a) Residence No. St Joseph's Hosp. St., Ward Meade Pl

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lithuania

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lithuania

14- (Informant) John Liveris

(Address) St Jos. Hospital

15- Filed JAN 13 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-11-25

17- I HEREBY CERTIFY, That I attended deceased from Dec. 25 19 24 to Jan. 11, 19 25 that I last saw him alive on Jan 11 19 25 and that death occurred, on the date stated above, at 11:05P m.

The CAUSE OF DEATH was as follows:

Cerebro Spinal Syphilis

(Duration) 15 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) J. B. Brohawn M. D

1-12 19 25 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy CROSS A. A.	Jan. 15. 1925
20-UNDERTAKER,	ADDRESS
John Grebliauckas	425 S Paca St

C. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 94018

CERTIFICATE OF DEATH.

49

D 94018

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Colonial Hospital ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Hylang

(a) RESIDENCE NO. 1527 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that ... may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Aug 26, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Hylang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary George

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Sam Jacobson

(Address) 1527 Fleet St

15 Filed JAN 13 1925 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1925

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1924, to Jan 10, 1925, that I last saw him alive on Jan 10, 1925, and that death occurred, on the date stated above, at 5 20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

Hypertrophied Prostate

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical data

(Signed) L. K. Fargo, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Jan. 14 19,

20 UNDERTAKER George J. Rust

ADDRESS 1735 Hanover